MONTESSORI METHODS FOR DEMENTIA™ IN ONTARIO LONG-TERM CARE

HOMES: STAFF PERCEPTIONS OF FACTORS AFFECTING IMPLEMENTATION

By KATE DUCAK, B.A. (HONS.)

A Thesis Submitted to the School of Graduate Studies in Partial Fulfillment of the

Requirements for the Degree Master of Arts

MONTESSORI METHODS FOR DEMENTIA™ IN ONTARIO LTC HOMES

McMaster University MASTER OF ARTS (2012) Hamilton, Ontario (Health and Aging)

TITLE: Montessori Methods for Dementia™ in Ontario Long-Term Care Homes: Staff

Perceptions of Factors Affecting Implementation

AUTHOR: Kate Ducak, B.A. (Hons.) (McMaster University)

SUPERVISOR: Dr. Margaret Denton

NUMBER OF PAGES: xii, 172

Abstract

Objectives: Research shows that Montessori-based activities can help address responsive behaviours experienced by persons with dementia by increasing their participation in and enjoyment of daily life. The purpose of this study was to investigate staff perceptions of factors that affect the implementation of Montessori Methods for Dementia™ (MMD) in Ontario long-term care (LTC) homes. **Methods**: Qualitative data was obtained during semi-structured telephone interviews with 17 participants who were putting MMD into practice in Ontario LTC homes. The study was guided by a political economy of aging perspective using thematic analysis to elucidate the various factors that affected the implementation of MMD. **Results**: Several themes emerged from the data: Regulating and Funding Medical Practices; Shifting Practice Amidst Resistance to Change; Educating and Understanding; Seeing Results is Believing; Being Supported; (Re-)Connecting People and Passions; and Improving Residents' Quality of Life. Barriers such as insufficient funding and negative attitudes toward activities and MMD reinforced a task-oriented biomedical model of care, whereas various forms of support and understanding helped put MMD into practice as a person-centred program, which improved the quality of life of residents with dementia, staff and family members. **Conclusions**: The results from this research can help ensure that MMD are as practical and easy to implement as possible despite perceived barriers so that persons with dementia in LTC and their partners in care can have a good quality of life. The findings include suggestions for future research, reducing staff hierarchies and ensuring there is sufficient organizational, financial, educational, and personal support.

Acknowledgements

I would like to thank my supervisor, Dr. Margaret Denton, for her advice and support during my thesis development and writing. Her mentorship, insight and experience greatly helped me to reflect upon and improve my skills. I am also very appreciative for my thesis committee members, Gail Elliot, Dr. Ellen Ryan, and Dr. Sherry Dupuis, for their perspectives and suggestions which contributed to my academic growth. Margaret, Gail, Ellen and Sherry's passion for gerontology and their accomplishments are inspiring.

I would also like to thank my family members and friends who have encouraged and supported me during my graduate studies and the many years before it. In particular I would like to thank my husband, Mike, for his unrelenting encouragement, patience, and love. As well, I am appreciative of my Grandma Jean and her experiences with Alzheimer's and Parkinson's diseases as she was my motivation for studying gerontology and pursuing this field of work. I also consider my Health and Aging graduate colleagues among my friends. Go team nerd!

Lastly, I would like to thank everyone who participated in this study. They took time from their busy schedules to answer my questions, share their experiences, and provide me with many insights. It is obvious that they enjoy working with persons with dementia in long-term care and that the benefits outweigh the challenges they are striving to overcome. This research would not have been possible with them.

I would also like to acknowledge the generous financial support that helped make my graduate studies possible. Firstly, I would like to thank the Department of Health,

Table of Contents

List of Tables and Figures

<u>List of Abbreviations</u>

LTC: long-term care

MMD: Montessori Methods for Dementia™

PSW: personal support worker

Declaration of Academic Achievement

This master's thesis was written by Kate Ducak under the supervision of Dr. Margaret Denton in conjunction with Gail Elliot, Dr. Ellen Ryan and Dr. Sherry Dupuis. Thus, Kate conducted the majority of the work involved with the study's design, data collection, and data analysis.

1.0 Introduction

Many residents in Ontario long-term care (LTC) homes have Alzheimer's disease or another form of dementia, and they may also experience responsive behaviours due to unmet needs (Canadian Institute for Health Information (CIHI), 2010; Dupuis & Luh, 2005). The nature of responsive behaviours can range from mild to severe, and they are usually a verbal or physical communication of an unmet need (Dupuis & Luh, 2005). LTC homes in Ontario are inadequately funded and staffed which makes it difficult for residents to receive an appropriate level of care and have a good quality of life (Dupuis, Smale & Wiersma 2003; Sharkey, 2008; Smith, 2004; Stolee et al., 2005). Most residents with dementia spend the majority of their days in LTC alone, doing nothing, with few opportunities for social interaction, which negatively affects their well-being (Brooker, Wooley & Lee, 2007; Cohen-Mansfield, 2000; Dupuis & Luh, 2005; Logsdon, 2000; Schreiner, Yamamoto, & Shiotani, 2005). Research shows that engagement in meaningful activities can beneficially affect the behaviour and sociability of persons with dementia (Bowie & Mountain, 1997), whereas task-based practices and routines have been identified as barriers to providing quality dementia care (Murphy, 2007). But which activities are most useful in this context and what are the factors that affect whether or not they are successfully put into practice?

Montessori-based activities for older persons with dementia can increase their participation in and enjoyment of activities while decreasing their levels of fear, anger, anxiety, agitation, and social withdrawal (Camp et al., 1997; Camp & Mattern, 1999; Giroux, Robichaud, & Paradis, 2010; Jarrott, Gozali, & Gigliotti, 2008; Judge, Camp, &

Orsulic-Jeras, 2000; Orsulic-Jeras, Judge, & Camp, 2000; Schneider & Camp, 2002; Vance, Camp, Kabacoff, & Greenwalt, 1996). Montessori Methods for Dementia™ (MMD) are person-centred approaches that can be implemented by staff who work in LTC homes or in other settings with persons with dementia. It is a research-based intervention that has the potential to improve the quality of life of persons with dementia while broadening care partners' understanding of both the person and the disease (Elliot, 2011). Quality of life can be described as the subjective feeling of well-being, satisfaction of personal needs, and contentment with good living conditions (Robichaud, Durand, Bedard, & Ouellet, 2006). Person-centred programs using Montessori-based activities are a way to increase the confidence and abilities of a person with dementia by creating activities, roles and routines based on her or his unique needs and history.

Researchers have found that adequate organizational support is required for staff who implement a person-centred program so that it can successfully be put into practice (Aylward, Stolee, Keat, & Johncox, 2003; Garbett & McCormack, 2002; McCormack, Manley, & Walsh, 2008; McCormack, 2010; McCormack & McCance, 2006; Murphy, Shea & Cooney, 2007), and that its feasibility needs to be assessed with a consideration of how individual, organizational, and structural variables can affect the desired outcome (Edvardsson, Winblad, & Sandman, 2008). No research has been conducted yet to determine which factors affect the ability of LTC staff to put MMD into practice with residents with dementia. In order to address this gap in the literature, this master's thesis investigated staff perceptions of factors that affect the implementation of MMD in Ontario LTC homes.

2.0 Literature Review

This literature review will discuss the topics that are most relevant to this research. It begins with the theoretical perspective used during the study, followed by an overview of LTC homes in Ontario, a synopsis of residents who live in LTC homes, the recreation and nursing staff members that work there, and families who visit their relatives in LTC. Next is a discussion of the importance of person-centred care in LTC and Montessori-based activities for residents with dementia. This chapter concludes with an overview of the factors that affect the implementation of continuing education and person-centred programs in LTC, namely, individual, program-related, organizational and structural factors, followed by a literature review summary.

2.1 Theoretical Perspective

The theoretical perspective used to inform this study was the political economy of aging. The political economy of aging can be used to reveal the implications of structural forces and processes that contribute to the social constructions of older adults, aging and social policy (Estes, 2001). A key concept within the political economy of aging approach is that public policies result from social struggles and dominant power relations settled within the state which directly influence the lives of older persons (Quadagno & Reid, 1999). As such, the political economy of aging highlights the interconnections between the individual (micro-level), organizational and institutional (meso-level), and societal (macro-level) aspects of aging (Estes, 2001). The political economy of aging was devised by Dr. Carroll Estes (2001) to integrate the approaches of gerontology, sociology,

economics and political science using a cross-section of critical, conflict, cultural and

feminist theories since these disciplines and theories do not adequately address the various

aspects of aging on their own. The aforementioned theories and disciplines tend to focus

on either the micro-level or macro-level while the political economy of aging encompasses

the multilevel relations between individuals, social processes and social structures so that

all levels are viewed as interdependent (Estes, Linkins, & Binney, 2001). Basically, the

political economy of aging is a multilevel analytical framework that focuses on how the:

> conflicting and competitive multidirectional relationships between postindustrial
> capital, the state, and the sex/gender system create and incorporate new institutional
> actors such as the "medical-industrial complex" and "the aging enterprise." Centred
> within this model is the public/citizen where the macro-levels and micro-levels are
> more deeply explored. … Finally, ideology is a key element in defining the issue of
> aging and determining how policies address aging. (Estes, 2001, pp. 1-2)

The medical-industrial complex refers to the multibillion dollar health care industry that is

comprised of hospitals, LTC homes, pharmaceutical companies, health insurance

companies, doctors, etc., whose main goal is to generate profits rather than deliver quality

health services (Estes, Harrington, & Pellow, 2001). Similarly, the aging enterprise

capitalizes on the needs of older adults by providing them with services through the

businesses, public institutions and social policies associated with the medical-industrial

complex (Estes, Harrington, et al., 2001). The biomedicalization of aging has substantially

contributed to the expansion of the medical-industrial complex, the aging enterprise and

the professions within them by providing older adults with profitable acute care and LTC

services and products (Estes, Mahakian, & Weitz, 2001). Biomedicalization refers to the

"process by which medical definitions and practices are applied to behaviours,

psychological phenomena, and [bodily] experiences not previously within the conceptual

or therapeutic scope of medicine" (Davis, 2010, p. 211), leading to medical management, treatment and transformation of them (Clarke & Shim, 2011; Davis, 2010).

Regarding the different levels within the political economy of aging, the social constructions of older adults, aging and social policy result from processes at the level of the state and economy (macro-level) which can influence the experience of older adults and those who care for them (micro-level), yet individuals actively engage in interactions with other people and with institutional and organizational structures (meso-level) that contribute to their personal experiences as well as to society (Estes, Linkins, et al., 2001). Therefore, the political economy of aging can provide insight into how individuals, organizations, institutions, social policies, social structures, and the relationships between them affect MMD program implementation in LTC homes.

2.2 Long-Term Care Homes in Ontario

There are various structural and organizational factors of LTC homes in Ontario that may affect the ability of staff to implement MMD. LTC homes in Ontario provide services for persons 18 years of age or older who are no longer able to live independently in their own home or in their community, such as in assisted living centres or supportive housing (Community Care Access Centre (CCAC), 2012a; Ministry of Health and Long-Term Care (MOHLTC), 2012a). LTC homes provide 24-hour residential care and supervision for persons needing assistance with activities of daily living and personal care as well as laundry services, pastoral services, and social and recreational programs (CCAC, 2012a; MOHLTC, 2012a). LTC homes are governed by provincial legislation, the Long-

Term Care Homes Act, 2007, where the Ministry of Health and Long-Term Care sets and

enforces provincial standards and policies which determine the services that LTC residents

receive and how the home is managed (Sharkey, 2008). Although the Ministry funds the

care that residents receive, residents pay for their accommodation costs through a co-

payment since LTC is not a publically insured service under the Canada Health Act (Berta,

Laporte, Zarnett, Valdmanis, & Anderson, 2006; CCAC, 2012b). Those who do not have

enough income to pay for the basic monthly accommodation rate, currently $1674.14 in

Ontario, can apply for a rate reduction through the Ministry (CCAC, 2012b; MOHLTC,

2012a). As of 2011, there were 642 LTC homes in Ontario providing care to more than

75,000 residents (MOHLTC, 2011a, 2012b).

The demand for LTC in Ontario has steadily increased in the last 20 years as a

result of the aging population. The main factors which affect quality of care and how

services are delivered to residents are the LTC home's size and profit status. The size of a

LTC home influences its organizational structure and performance through its capacity to

acquire fundamental resources such as capital, staff, and knowledge (Berta, Laporte, &

Valdmanis, 2005). In Ontario, most LTC homes are small for-profit homes with less than

150 residents (42.9%), followed by small non-profit homes (24.8%), large non-profit

homes (16.7%), and large for-profit homes (15.6%) (Ducak & Keller, 2011). For-profit

homes comprise the majority of LTC homes in Ontario (58.5%) (Ducak & Keller, 2011;

McGrail, McGregor, Cohen, Tate, & Ronald, 2007). The shift to a for-profit dominated

LTC sector originates with the Mike Harris Conservative government in 1998 when they

spent one billion dollars to create 20,000 new LTC beds with 68% of the contracts

awarded to for-profit companies (National Union of Public and General Employees (NUPGE), 2007). The profit status of a LTC home affects the home's organizational priorities and management where non-profit homes reinvest their revenues to improve services for residents, while for-profit homes generate revenue for their shareholders and, therefore, are not as likely to use profits to improve services (Berta et al., 2005).

The Ontario government funds LTC homes based on resident care requirements where the amount paid per resident requiring a similar level of care is the same despite whether the resident is in a for-profit or non-profit facility (McGrail et al., 2007). Like hospitals, LTC homes are labour-intensive institutional environments where staffing costs constitute a large portion of the facility's expenditures (McGrail et al., 2007). The Residential Care Facilities Survey reported that for-profit Ontario LTC homes had considerably lower staffing levels than other types of ownership, and that non-profit facilities had the highest staffing ratios (Statistics Canada as cited in Berta et al., 2005). In comparison to the United States where minimum staffing levels were enacted in the early 1990s, Canada has no minimal requirements for staffing in its LTC homes. Because for-profit LTC homes use some of their funding to generate profits, reducing staffing costs is one of their most lucrative tactics (McGrail et al., 2007). Although this operating strategy may be cost-effective, it could result in increased costs to the health care system as non-profit LTC homes have higher staffing levels and improved resident care outcomes than for-profit homes (McGrail et al., 2007; McGregor et al., 2005; Rachlis, 2000). Research by Hirdes (2002) verifies this as he found that the inability of LTC homes to handle the complex needs of residents due to insufficient funding leads to longer stays in acute care

hospitals, which perpetuates residents' health care needs and costs. More recent data also supports these findings as the Ontario Health Coalition (2008) reported that for-profit LTC homes had the lowest levels of care as opposed to the highest levels provided by publicly-owned municipal homes. Similarly, the largest increases in hours of care from 2004 to 2007 occurred in municipal LTC homes (14.2%), followed by non-profit and charitable LTC homes (10.2%), and for-profit homes (5%) (Ontario Health Coalition, 2008).

2.2.1 Residents Who Live in LTC Homes

Persons who live in LTC homes are known as residents. Individuals with Alzheimer's disease and related dementias represent an increasing proportion of LTC residents and require more specialized treatment by staff trained to provide dementia care, thus necessitating higher staffing levels. Approximately 60% to 80% of residents have some form of cognitive impairment, 57% have Alzheimer's disease and/or another type of dementia with 37% experiencing severe or very severe cognitive impairment (CIHI, 2010). Additionally, 58% of residents with dementia express behaviours that are referred to in the literature as "wandering", "verbal abuse", "physical abuse", "disruptive", and "resists care" (CIHI, 2010, p. 11). These negative interpretations and descriptions of residents' behaviours tend to result from a reductionist biomedical model of care rather than being viewed as meaningful ways of communicating (Dupuis & Luh, 2005; Dupuis, Wiersma, & Loiselle, 2012). The average LTC resident is 83 years old with those younger than age 65 comprising less than 6% of the LTC population (Sharkey, 2008). Changes to the eligibility definitions for complex continuing care and mental health care as well as shorter stays in acute care hospitals have resulted in an increase in resident acuity of nearly 30% since

1992 (Ontario Health Coalition, 2008). More than 85% of residents require high levels of care including constant supervision and assistance in performing one or more activities of daily living such as dressing, eating or toileting (Sharkey, 2008). As aforementioned, residents currently need more care and individualized services due to longer life expectancies and advances in medical treatments. Knowing these details about residents provides a general understanding of what their needs are and how LTC staff might work with them using MMD activities.

2.2.2 Staff Who Work in LTC Homes

There are many staff members who work in LTC homes, such as administration, management, housekeeping, dietary, social work, pastoral care, maintenance, etc. But the two groups of staff members who are most relevant regarding this research are recreation and nursing staff. Recreation staff are the primary group who facilitate recreational activities and implement programs such as MMD. Nursing staff provide personal care and assist residents with their activities of daily living.

2.2.2a Recreation staff

While nursing staff attend to the quality of care of residents, recreation staff help to improve residents' quality of life. Recreation staff play a key role in LTC homes as they create and maintain programs such as social activities, recreation, leisure or hobbies based on residents' interests (Berta et al. 2006; MOHLTC, 2011b). Although these LTC staff members will be referred to as 'recreation staff' in this paper, their titles vary as they may be known as 'activity staff', 'programs staff', or 'recreation therapists' in some homes. The programs that recreation staff develop and implement are essential to the well-being of

LTC residents as recreational activities have been proven to: help them transition and adjust to life in LTC by developing a sense of belonging and community (Coppola, Feldheim, Kennaley, & Steinberg, 1990; Sullivan, Pedlar, & Miller, 2002); improve their physical and cognitive functioning (Buettner, 1988); increase their opportunities for social interactions to maintain and develop friendships and family connections (Crispi & Heitner, 2002; Katsinas, 2000; Trzinski & Higgins, 2001); reduce anxiety, agitation, and depression (Buettner, 1995, 1999; Buettner & Ferrario, 1997; Buettner & Fitzsimmons, 2002; Fitzsimmons, 2001; Rosling & Kitchen, 1992; Ward, Kamp, & Newman, 1996); increase their feelings of autonomy and control (Card, 1989; Duncan-Myers & Huebner, 2000; Lilley & Jackson, 1990; Martin & Smith, 1993; Phinney, Chaudhury, & O'Connor, 2007; Shary & Iso-Ahola, 1989; Voelkl, Fries, & Galecki, 1995); and help sustain and build their morale and self-esteem (Shary & Iso-Ahola, 1989). Similarly, provincial reviews of Ontario LTC homes by Monique Smith (2004) and Shirlee Sharkey (2008) found that recreation staff and activities are essential to enhancing residents' quality of life. Their reports recommended an increase to the capacity of recreation staff so that they could provide more recreational activities, coordinate activities for specific cohort groups, such as younger residents and persons with advanced dementia, and have more time to provide comfort measures such as companionship, personal attention and support (Sharkey, 2008; Smith, 2004).

Increased numbers of recreation staff in LTC homes are much needed as the most recent data from a comprehensive report on Canadian LTC recreation programs (Dupuis et al., 2003) found that the staff-to-resident ratio in Ontario was extremely low with one

recreation staff member responsible for 26 residents on average. Low staff-to-resident ratios affects the number of residents participating in LTC recreation programs as the percentage of residents involved tends to decrease with insufficient staff support. Higher staff-to-resident ratios enable recreation staff to provide more individualized activities that are suited to the needs and abilities of persons with dementia (Volicer, Simard, Heartquist Pupa, Medrek, & Riordan, 2006). Thus, higher staff-to-resident ratios are essential for person-centred practices. Activity programs in LTC homes usually involve recreation staff gathering the majority of residents in a home area, leading an activity for 30 to 45 minutes and then moving on to facilitate an activity with other residents in another area (Volicer et al., 2006). When not engaged in an activity, residents with dementia typically spend 60% of their day in a solitary situation, doing nothing 49% of the time, whereas residents are seven times more likely to express happiness during an activity with 44% of residents expressing happiness only during that time (Schreiner et al., 2005). The boredom and isolation that residents with dementia experience during inactivity lead to many of the behavioural responses they display (Cohen-Mansfield, 2000; Dupuis & Luh, 2005; Logsdon, 2000). Therefore, it is crucial for recreation staff to engage residents with dementia in meaningful activities that improve their well-being so that they are not spending their days bored and alone.

2.2.2b Nursing staff

Like recreation staff, nursing staff also have an important role in LTC homes as they frequently interact with residents and maintain their physical health. Nursing practices in LTC are derived from the biomedical model of acute care and traditionally

focus on residents' physical aspects of activities of daily living yet nursing staff have been at the forefront of critiquing medicalized care and arguing for person-centred approaches. The majority of LTC staff who provide nursing care to residents are women. Most front-line staff are female personal support workers (PSWs), also known as 'health care aides' or 'nursing aides', supervised by female nurses (Banerjee et al., 2008; Brookman, 2008; Health Professions Regulatory Advisory Council (HPRAC), 2006). PSWs provide 90% of the care since the under-funding of LTC homes necessitates lower paid and lower skilled staff (Banerjee et al., 2008; Brookman, 2008; HPRAC, 2006). These staff members are committed to caring for residents in a respectable manner but often report that there is not enough time, training or assistance to provide quality, individualized care as opposed to rushed, task-oriented care (Dupuis & Wiersma, 2006, 2007). Similarly, workers, residents, and their families consider staff shortages the main factor which negatively affects the quality of care residents receive as well as the home environment (Banerjee et al., 2008; NUPGE, 2007; Ontario Health Coalition, 2008; Sharkey, 2008). Somewhat surprisingly, a high proportion of nursing staff also do not have adequate training regarding geriatric mental health care and dementia care (Moyle, Hsu, Lieff, & Vernooij-Dassen, 2010). Staffing shortages and under-funding can limit the ability of LTC staff to attend training sessions as workers typically participate on their own time with their own money since their employer cannot afford to pay for it or chooses not to pay, and there likely is no staff member to replace them while away (Aylward et al., 2003; Morgan, Stewart, D'Arcy, Forbes, & Lawson, 2005; Sharkey, 2008; Stolee, et al., 2005). Not only does a lack of training and staffing shortages affect the quality of care that nursing staff provide, it can

also increase their risk of being injured by residents when responding to behaviours of a more severe nature, contributing to a stressful work environment (Banerjee et al., 2008; Morgan et al., 2005; Sharkey, 2008). The stress experienced by nursing staff and the specialized care residents require underscore the need for an appropriate amount of staffing and training so that LTC homes are an enjoyable place to both work and live.

2.2.3 Family Members Who Visit their Relatives in LTC Homes

In addition to residents and staff, family members are also an essential part of life in LTC homes and, thus, they may affect the ability of staff to put MMD into practice. Although not all LTC residents have family members who visit them regularly, most family members visit frequently. Family members can be an active part of the health care team or 'partners in care' in LTC and not just a source of their relatives' historical or medical information that staff can refer to (Duncan & Morgan, 1994; Hasselkus, 1992). Some family members may have had an active role regarding their relatives' emotional, intellectual, spiritual, and/or physical needs before she or he moved into LTC and they, therefore, continue to be an important partner in care (Bowers, 1988; Dempsey & Pruchno, 1993; Dupuis & Norris, 1997; Rubin & Shuttlesworth, 1983; Schwartz & Vogel, 1990; Shuttlesworth, Rubin, & Duffy, 1982; Zarit & Whitlatch, 1992). Researchers have found that some family members view their roles as meaningful, purposeful and integral to providing high quality of care for their relatives in partnership with LTC staff (Bowers, 1988; Duncan & Morgan, 1994; Dupuis & Norris, 2001). There is great diversity regarding how families define their roles in LTC homes depending on how they are adjusting to the transition (Dupuis & Norris, 2001). The continuity in care that family

members provide may be referred to as a 'caregiving career' (Dupuis & Norris, 1997) but family members can also be 'forgotten clients' (Pratt, Schmall, Wright, & Hare, 1987) as the focus tends to be on LTC residents even though family members play pivotal roles and have their own needs as they deal with the institutionalization and gradual decline of their relatives (Dupuis & Norris, 1997). Therefore, creating strong partnerships between family members, residents and staff in LTC is essential to ensuring the quality of care residents receive and the quality of life of everyone involved (Dupuis & Norris, 1997; 2001; Dupuis & Pedlar, 1995).

Activities are one way to facilitate strong partnerships and positive interactions when family members visit (Hellen, 1998) as they provide family members with a meaningful role and can improve the quality of communication with their relatives (Schneider & Camp, 2002). LTC staff can proactively organize activities that family members can participate in with their relatives (Dupuis et al., 2003; Hellen, 1998; Smith, 2004). Montessori-based activities are conducive to beneficial, interactive visits with residents with dementia as they have been found to increase residents' engagement with family members and the number of observed positive changes in residents during activities while decreasing family members' self-reported burden (Schneider & Camp, 2002). Other research suggests that the percentage of resident and family involvement in activities decreases when there is a low staff-to-resident ratio as is typically found in Ontario LTC homes (Dupuis et al., 2003; Sharkey, 2008; Smith, 2004). This reinforces the need for an adequate number of LTC recreation staff to provide family members and residents with

activities which can improve the quality of visits as well as their relationships (Dupuis & Pedlar, 1995).

2.3 The Importance of Person-Centred Care in LTC Homes

Since LTC residents are largely dependent on staff for assistance with daily activities and routines, their lives become regimented by LTC institutional practices. Residents can become objectified by staff and institutional policies as the regulations and delivery of LTC emphasize meeting their bodily needs appropriately, safely, and cost-efficiently (Lanoix, 2005; Wiersma & Dupuis, 2010). Caring requires relationship building whereas work in LTC is mainly task-oriented and can be conducive to an apathetic staff attitude (Wiersma & Dupuis, 2010). The focus on tasks has detrimental consequences for residents as it leads staff to view them as 'institutional bodies' with their physical needs taking priority over their psychosocial ones (Wiersma & Dupuis, 2010). Thus, caring work must be separated from financially-driven efficiency priorities to prevent systemic abuse and instead respect residents' dignity and human identity (Lanoix, 2005). In gerontological research in recent decades, there has been a movement away from providing services and care for older adults with dementia based on the reductionist biomedical model of care, which essentially views dementia as a neurologic phenomenon, to a more holistic, person-centred understanding that takes into account the other aspects of the individual such as her or his perspective, well-being, strengths, dignity and independence (Brooker, 2004; Dupuis, Gillies et al., 2012; Edvardsson et al., 2008). Since the biomedical model encourages staff to provide task-oriented care – care which treats a

person's symptoms in isolation from any other related symptom, illness, or need the person may be experiencing – it is considered the opposite of person-centred care.

The concept of person-centred care was derived from Rogerian psychotherapeutic terminology which focused on client-centred psychotherapy, communication, and relationships, and was extended to the dementia care context by Dr. Tom Kitwood (Brooker, 2004). Kitwood (1997) was a social psychologist who viewed the challenges experienced by persons with dementia and their care partners to be a result of the interaction between the person's cognitive impairment and malignant psychosocial factors. Malignant psychosocial factors refers to objectifying, disempowering, stigmatizing, infantilizing, disparaging and/or intimidating processes that people may unknowingly cause when interacting with persons with dementia (Kitwood, 1997). These processes erode rather than enable the personhood of persons with dementia and their relationships with others likely due to a biomedical focus of providing care (Kitwood, 1997). Kitwood was interested in the perspective of persons with dementia, their abilities, and their personhood, which he defined as "a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust" (Kitwood, 1997, p. 8). Essentially, person-centred care is a holistic philosophy and way of life that values personhood and the need for social interaction regardless of one's physical or cognitive abilities. Kitwood's person-centred care philosophy has been expanded to include relationship-centred care that highlights even further the relational nature of care (Nolan, Davies, Brown, Keady, & Nolan, 2004). Relationship-centred care emphasizes the caring relationships and interdependence

between everyone involved rather than solely the person with dementia so that the contributions and experiences of all partners in care, including family members and formal care partners, are not neglected (Dupuis, Gillies et al., 2012; Nolan et al., 2004; Nolan, Ryan, Enderby, & Reid, 2002).

Likewise, the term 'responsive behaviours' is relatively new in the health and aging literature as it was needed to replace older, demeaning and objectifying terms such as 'disruptive', 'challenging', or 'aggressive' behaviours. Dr. Sherry Dupuis, her colleagues and community members at the Murray Alzheimer Research and Education Program (MAREP) at the University of Waterloo define responsive behaviours as:

> a term originating from, and preferred by, persons with dementia that represents how their actions, words and gestures are a response, often intentional, to something important to them. Persons may use words, gestures, or actions to express something important about their personal, social, or physical environment. Responsive Behaviours adhere to the following principles:
> 1. All personal expressions (words, gestures, actions) have meaning.
> 2. Personal expressions are an important means of communicating meanings, needs, concerns.
> 3. Care partners require a multidimensional lens that seeks understanding of others' expressions. (MAREP, 2012)

The reasons or 'triggers' for behaviours can then be more broadly considered outside of the biomedical aspects of the disease, such as in the person's physical or social environment, instead of just within the individual so that what is causing an action can be identified and any unmet personal needs satisfied (Dupuis & Luh, 2005; MAREP, 2012). Terms that were formerly used to describe the behaviour of persons with dementia were from the perspective of staff and academics which they considered to be disruptive, aggressive, problematic or challenging. When behaviours and personal expressions are thought about in this way, residents displaying these behaviours become labelled by them and often

legitimate responses are dismissed or overlooked (Dupuis, Wiersma et al., 2012; MAREP, 2012). A responsive behaviour philosophy is consistent with person-centred care as it focuses on holistically understanding the meaning behind the behaviour and the needs of persons with dementia from their perspectives (Dupuis, Wiersma et al., 2012).

In order to transition from a biomedical model of care to a person-centred one, the administrators and staff of LTC homes need to know what person-centred care is and how to implement it. A framework for person-centred practice developed by McCormack and McCance (2006) consists of four constructs: prerequisites, the care environment, person-centred processes, and outcomes. Prerequisites are the personal attributes of the worker which include professional competence, having interpersonal skills, and being dedicated to their job, as well as knowing oneself, and one's beliefs and values (McCormack et al., 2010; McCormack & McCance, 2006). The care environment is the physical and social context where care is provided which consists of suitable staff skill mix, systems that enable shared decision making and power among all who work and live in the care setting, beneficial staff relationships, organizational support, and encouraging innovation and risk taking (McCormack et al., 2010; McCormack & McCance, 2006). Person-centred processes involve the delivery of care through various means such as incorporating and engaging the resident's beliefs and values into daily activities, having a sympathetic presence, sharing the decision making process, and giving holistic care (McCormack et al., 2010; McCormack & McCance, 2006). The main goal of this framework is to produce and sustain person-centred care outcomes such as satisfaction with the care provided and received, involvement with care, feeling content, and the creation of a therapeutic

environment (McCormack et al., 2010; McCormack & McCance, 2006). For person-centred care to flourish within a regulated health care facility, such as a LTC home, the successful implementation of it and related practice changes are dependent more on the support of the organization and broader structural factors than the individual staff members (McCormack & McCance, 2006; Garbett & McCormack, 2002). Therefore, the care environment and related culture change within the organization greatly influence the ability for person-centred care to become established in practice (McCormack et al., 2010; McCormack, Manley, & Walsh, 2008; McCormack & McCance, 2006).

2.4 Montessori-Based Activities for LTC Residents with Dementia

One way to maintain the personhood of residents with dementia who live in LTC homes is to provide them with person-centred activities based on their roles, needs, interests and abilities. Research has identified a lack of meaningful activity and social interaction, and boredom to be some of the main triggers of responsive behaviours (Cohen-Mansfield, 2000; Dupuis & Luh, 2005; Logsdon, 2000) and, thus, activities can beneficially affect the behaviour and sociability of residents with dementia (Bowie & Mountain, 1997; Kolanowski, Litaker, & Buettner, 2005). The connection between small group or individualized purposeful activities and the quality of life of LTC residents was evidenced in a study by Murphy and colleagues (2007) where residents who did not have the opportunity to participate in meaningful activities were usually frustrated and disengaged. They also found that a flexible management style and organizational structure beneficially affected quality of life by facilitating resident choice, and personalized care

and activities (Murphy et al., 2007). LTC homes that focused on routine, on the other hand, negatively affected residents' quality of life (Murphy et al., 2007). Similar findings were reported by Zimmerman and colleagues (2005a) where improved quality of life in residents was related to LTC homes that had staff trained in dementia care, had positive attitudes toward residents, and encouraged activity participation.

The majority of LTC homes tend to involve residents in group activities which can be difficult for persons with advanced dementia to participate in, especially in large groups, (Giroux et al., 2010; Orsulic-Jeras et al., 2000; Volicer et al., 2006) but there is growing evidence that using an individualized approach with persons with dementia beneficially meets their cognitive, emotional, physical and social needs and abilities, thus improving their quality of life (Buettner, 1999; Gerdner, 2000; Giroux et al., 2010; Kolanowski et al., 2005; Orsulic-Jeras, Schneider, Camp, Nicholson, & Helbig, 2001; Russen-Rondinone & DesRoberts, 1996; Van Haitsma, 2000; Van Haitsma & Ruckdeschel, 2001). Montessori-based activities provide more structure, individualized attention, opportunities for interaction, and adequate sensory and cognitive stimulation for persons with dementia than regular activities (Camp & Mattern, 1999; Judge et al., 2000; Orsulic-Jeras et al., 2001), such as bingo or music, which typically involve a large group of residents. Montessori-based activities have also been found to produce more positive effects on persons with dementia as measured by increased lengths of active participation and enjoyment compared to regular activities (Camp & Mattern, 1999; Giroux et al., 2010; Judge et al., 2000; Orsulic-Jeras et al., 2000). Montessori approaches can increase the amount of active engagement in and enjoyment of activities while decreasing behaviours

such as agitation and social withdrawal, and lowering levels of fear, anger and anxiety experienced by persons with dementia (Camp et al., 1997; Camp & Mattern, 1999; Giroux et al., 2010; Jarrott et al., 2008; Judge et al., 2000; Orsulic-Jeras et al., 2000; Schneider & Camp, 2002; Vance et al., 1996). When persons with dementia are given an activity or task that does not correspond with their interests and abilities, they can become anxious, agitated, or apathetic (Camp, Vance, Kabacoff, & Greenwalt, 1996). Providing activities that match the interests and abilities of persons with dementia can help address responsive behaviours and improve their quality of life by satisfying their basic psychological needs for self-esteem, accomplishment and well-being (Giroux et al., 2010). Therefore, providing LTC residents with dementia with Montessori-based activities can facilitate engagement, enjoyment, and interaction using meaningful, person-centred activities that are based on their unique needs and abilities.

Montessori-based activities utilize the learning principles originally created by Dr. Maria Montessori and further developed by Dr. Cameron Camp in order to encourage engaged learning and participation among persons with dementia through task breakdown, guided repetition, progressive and modifiable difficulty, and matching the demands of the activity to the abilities, skills and interests of the person (Camp, 1999, 2006; Malone & Camp, 2007). Montessori activities are designed to use procedural memory, which is more readily accessed by those with dementia than is declarative memory, while also minimizing language demands and complex cognitive processing by placing external cues in the person's environment (Giroux et al., 2010; Malone & Camp, 2007). Declarative memory refers to the conscious acquisition and recollection of facts, experiences, and

information, whereas procedural memory refers to unconscious task performance, such as routines and skills (Butters, Delis, & Lucas, 1995). Structured repetition is a key part of the Montessori activity process for persons with dementia as they can learn new procedures via repeated practice since procedural memory remains intact during the course of the disease (Skrajner, Malone, Camp, McGowan, & Gorzelle, 2007). The activity sequence most commonly used in Montessori-based activities for persons with dementia includes inviting the person to participate in a meaningful activity based on his or her skills and interests, using familiar objects or materials, demonstrating how to complete the activity by breaking it down into simple steps, providing time and encouragement for the person to complete the activity, and ending by asking if the person would like to do the activity again another time (Malone & Camp, 2007). Basically, Montessori activities for persons with dementia are created based on the individual's level of ability using familiar and attractive materials that can be modified to fit the person's needs and abilities while allowing for self-correction since its external cues compensate for cognitive impairments (Malone & Camp, 2007; Orsulic-Jeras et al., 2001).

Seeing that person-centred programs using Montessori-based methods are a way to increase the confidence and abilities of persons with dementia by creating activities and roles based on their unique needs and history, Gail Elliot introduced the work of Camp to Ontario LTC homes. The *Montessori Methods for Dementia™ Focusing on the Person and the Prepared Environment* program was developed by Elliot at the Gilbrea Centre for Studies in Aging at McMaster University in conjunction with Camp and is delivered in a two-day workshop (DementiAbility, 2012; Elliot 2010, 2011). During the first day of the

workshop, participants learn about dementia, the differences between procedural and declarative memory, the principles of Montessori programming and its benefits for persons with dementia, and how to create Montessori-based activities (Elliot, 2010). The second day involves putting the knowledge into practice by creating and presenting Montessori activities as well as adapting existing activities or programs to become Montessori-based (Elliot, 2010). Since its inception, approximately 2,000 people have been educated in MMD techniques from a broad range of disciplines (G. Elliot, personal communication, July 30, 2012). When an analysis of the first 1,200 workshop participants was conducted it was discovered that the majority (57%) were comprised of recreation staff (Elliot, 2011). Other disciplines and persons who took the MMD training include administrators, students, volunteer services staff, case coordinators, family members and community programmers (16%), followed by nursing staff (12%), educators (7%), occupational therapists and physiotherapists (6%), and social work and psychology staff (2%) (Elliot, 2011). Although MMD can be used in any setting, it is mainly used by staff in LTC homes (62%), followed by community programs (15%), hospitals (10%), Alzheimer Societies (5%), day programs (3%), educational settings (3%), and other settings (2%) (Elliot, 2011). Some of the barriers to implementing MMD identified by workshop participants are staff attitudes, lack of knowledge about the program, and its benefits and effectiveness, the larger initial amount of time needed to implement the program, the costs and resources involved, and fear that it will contradict government regulations (Elliot, 2011). Although these are valid concerns, like any new activity or program introduced in a LTC home, there are creative ways of effecting change, most of which involve a gradual culture shift from one that is

based on the task-oriented biomedical model, to the more holistic person-centred care approach.

2.5 Factors that Affect the Implementation of Continuing Education & Person-Centred Programs in LTC Homes

Several factors that affect the implementation of continuing education and person-centred programs in LTC have been identified in the literature. These include: individual factors, such as the attitude of the staff member; program-related factors, such as how the training program itself can benefit or hinder its effectiveness and the application of it by staff; organizational factors regarding the internal policies and management of the LTC home; as well as structural factors which pertain to government regulations and funding. Out of all these considerations, the literature suggests that organizational factors are the most influential in determining if and how new knowledge and programs are successfully implemented in a LTC home.

2.5.1 Individual Factors

The individual factors that can affect the application of new knowledge or programming in LTC include the staff member's age, position, level of education, attitude, and years of experience. According to Stolee and colleagues (2005), the main aspects that influence the effectiveness of continuing education were appropriately trained staff, the age of staff (as those who are older can be resistant to change since their experience tends to be rooted in the biomedical model), routine (as some staff like to maintain daily work habits), and the staff member's attitude or beliefs toward older adults (which can reinforce ageism and custodial models of care). Nolan and colleagues (2008) also reported that effective

training programs need to address staff attitudes. The attitudes that staff have toward each other are also significant as there is a predominant belief that activities in LTC homes are to exclusively be provided by recreation staff with little or no expectation for staff from other disciplines to participate in or implement activities with residents (Skrajner et al., 2007; Volicer, et al., 2006). Involvement in activities tends to be resisted by LTC staff and management from other disciplines (Volicer et al., 2006), which recreation staff attribute to the lack of appreciation or respect they receive from other staff members and the lack of knowledge among other staff regarding the benefits of activities for residents (Dupuis et al., 2003; Smith, 2004). As well, the education level of staff is influential since there is typically a low degree of schooling among front-line workers who do not view continuing education as a priority compared to registered staff who receive tuition funding through their professional associations (Stolee et al., 2005). Funding for continuing education for recreation staff is also scarce as recreation is not a regulated profession in Ontario (Smith, 2004). Similarly, in regard to implementing training, a higher average staff age has been found to result in less application and retention of post-training knowledge in LTC (Corazzini et al., 2010). In a study of staff attitudes toward dementia care, Zimmerman and colleagues (2005b) determined that those who had been working in LTC for less than two years were more likely to adopt a person-centred approach than staff who had more years of experience. Having a person-centred attitude was also linked to increased job satisfaction and confidence in providing dementia care after receiving training (Zimmerman et al., 2005b). Additionally, a person-centred approach to care was more frequently reported by staff in newer LTC homes as well as by those who felt they were

well-trained which led Zimmerman and colleagues (2005b) to hypothesize that the relatively low prevalence of person-centred care in older homes indicates that a biomedical model of care is more predominant in those facilities.

2.5.2 Program-Related Factors

The key program-related factors that can influence the application of training programs in LTC are the program's design, content, delivery, instructor, location, credentialing, and follow-up support. Regarding the design of a program, predisposing factors include how the information is communicated and disseminated to staff, such as via lectures, videos, booklets, and/or hands-on practice, so that it can effectively change the person's attitudes and knowledge (Aylward et al., 2003; Green & Kreuter, 1991; Skrajner et al., 2007). Additionally, whether or not the training is successful can depend on the program's objectives and subject matter, and how they are conveyed to the participants by the instructor as well as where the training takes place (Beeber, Zimmerman, Fletcher, Mitchell, & Gould, 2010). It is also optimal if the training program and its instructors are standardized to ensure consistent delivery (Fletcher et al., 2010) with a credentialing system for participants (Hyer, Molinari, Kaplan, & Jones, 2010). Ontario research has found that the amount of new information presented during training can be overwhelming, that programs do not always consider the variance in staff education levels to ensure that the material is neither too simplistic nor too complex, and that mainly registered staff attend (Stolee et al., 2005). As well, it has been identified that staff who partake in a training program require follow-up support in the form of various resources and opportunities for networking. For instance, leaders or mentors in the workplace can aid

with the application of new knowledge and its long-term sustainability (McCainey et al., 2007; Nolan et al., 2008; Stolee et al., 2005, 2009). It is also beneficial if the training is comprised of interactive classes with multiple sessions and refresher follow-ups to assist with its retention and application in the workplace (Gould & Reed, 2009; Hyer et al., 2010; McCabe, Davison, & George, 2007; Moyle, et al., 2010; Rampatige, Dunt, Doyle, Day, & van Dort, 2009).

2.5.3 Organizational Factors

The organizational factors that can affect whether programs are put into practice in LTC are the internal policies and practices, space, materials and management/leadership of the home. As aforementioned, LTC homes in Ontario are highly regulated facilities that tend to be for-profit in nature. Furthermore, there has been a movement away from the traditional biomedical model of care towards a person-centred ideology of providing care which necessitates a culture shift in LTC homes. A literature review of LTC continuing education programs by Aylward and colleagues (2003) found that nearly 75% of the programs were implemented without any organizational support which impeded or prevented the new knowledge and skills learned by staff from being successfully transferred to the workplace. They noted that enabling factors, such as a modified work schedule, opportunities to practice, and accommodating internal policy changes, as well as reinforcing factors which support the application of new skills in the form of peer encouragement and feedback, were required in order to put the new knowledge into practice yet were largely absent (Aylward et al., 2003; Green & Kreuter, 1991). Other organizational characteristics common to LTC which obstruct new program

implementation include high levels of staff turnover, inadequate staffing levels, and strenuous workloads (Aylward et al., 2003; Nolan et al., 2008). Similarly, the main finding of Stolee and colleagues' (2005) investigation of workplace factors that affect the uptake of continuing education programs in Ontario LTC homes was that management support is the most influential factor, followed by sufficient resources, such as adequate levels of staff, funding and space, as well as on-going expert follow-up assistance. A lack of required equipment and materials to implement new programs are other internal factors (Nolan et al., 2008; Stolee et al., 2005).

Support from management was identified as a key factor in several other studies (Aylward et al., 2003; Beeber et al., 2010; Cerveo, 1985; Corazzini et al., 2010; Kuske et al., 2007; McCabe et al., 2007; Mitchell, Zimmerman, & Beeber, 2010; Moyle et al., 2010; Murphy, 2007; Nolan et al., 2008; Skrajner et al., 2007; Stolee et al., 2009) as organizational policy and practice changes are required to accommodate the application of new knowledge. LTC management "buy-in", such as cooperation and support, involves participating in, prioritizing and funding training, as well as coordinating schedules so that staff can attend with adequate coverage in their absence (Skrajner et al., 2007; Stolee et al., 2005). It is advised that LTC management should send staff members from various disciplines and departments to the training to increase its awareness and use and to reduce hierarchical staff structures by encouraging team-building so that all staff members can be a valued part of the multi-disciplinary care team (Skrajner et al., 2007; Smith, 2004; Volicer et al., 2006). Other organizational considerations include union rules regarding overtime, breaks, and compensation for travel costs (Stolee et al., 2005).

Management style at the LTC home has also been identified as an organizational factor that can promote or hinder the application of new learning and programs. Management practices can range from person-centred and empowering to task-oriented and hierarchal (Bishop et al., 2008; Corazzini et al., 2010). Cohen-Mansfield and Bester (2006) found that flexibility as a management strategy can facilitate person-centred policies and programming by permitting staff a high level of autonomy in their daily work which resulted in higher staffing levels, lower rates of staff turnover, and more home-like experiences for both residents and staff. However, considering that greater than 50% of the LTC homes in North America are chain-owned (Kruzick, 2004; McGrail et al., 2007; NUPGE, 2007), the decisions made by local management and administrators may be constrained by upper-management and organizational policies and directives (Corazzini et al., 2010). Therefore, the implementation of any new training or program requires long-term culture change and support across all management levels (Nolan et al., 2008) as the organizational environment greatly influences the likelihood of new knowledge being supported and successfully and sustainably put into practice.

2.5.4 Structural Factors

The main structural factors that influence knowledge acquisition and program application in LTC are funding, systemic ideologies, and government regulations. Firstly, LTC in Ontario is chronically under-funded which results in inadequate levels of management and staff, and less time to participate in training due to high workloads (Stolee et al., 2005). Recreation staff in Canadian LTC homes reported that lack of financial resources is one of their greatest challenges to providing recreation programs and

activities (Dupuis et al., 2003). Lopez (2006) and Lanoix (2005) attribute the government's insufficient funding of the LTC sector to the marginalized societal position of institutionalized older adults as a systemic effect of ageism. A comprehensive literature review by Nolan and colleagues (2008) on training and achieving culture change in LTC found that when resources are scarce, management focuses on regulatory and organizational requirements by routinely accommodating the physical needs of residents rather than the emotional and relational aspects involved with person-centred care. This is further exemplified by the proliferation of LTC programs that educate staff more on the physical and behavioural elements of care instead of person-centred care (Nolan et al., 2008), as is true with the required programs in the Ontario Long-Term Care Homes Act (MOHLTC, 2011b). The required programs mandated by the Act are: falls prevention and management; skin and wound care; continence care and bowel management; and pain management (MOHLTC, 2011b).

As for regulations in Ontario, the Ministry of Health and Long-Term Care's standards and practice guidelines largely shape the organizational policies and daily lives of those who live and work in LTC homes. The government's regulations are enforced by various levels of management and supervisors to ensure compliance (Kontos, Miller, Mitchell, & Cott, 2010) as well as unannounced visits from Ministry inspectors. In a study of PSWs in two southern Ontario LTC homes from 2007 to 2009, Kontos and colleagues (2010) discovered that staff frequently broke rules with the support of their supervisors as a means to provide individualized care since Ministry legislation restricted their ability to do so. Other LTC research also found that regular rule breaking was necessary as the level

of staffing funded by the federal system in the United States did not enable front-line staff to meet mandatory care standards (Lopez, 2007). Although the recently enacted Ontario Long-Term Care Homes Act seemingly mandates increased amounts of individualized care, its extensive number of specific regulations that are enforced by management and Ministry inspections with public sanctions for non-compliance likely perpetuates task-oriented treatment of residents rather than flexible, person-centred care. There are 335 official regulations with numerous subsections (MOHLTC, 2011b) and 193 related clauses in the Ontario Long-Term Care Homes Act (MOHLTC, 2011c). Since the Act came into effect in July 2010 there is no literature available yet regarding how its new and revised standards affect the implementation of new knowledge or person-centred programs in LTC. What is clear is that LTC homes are spending considerable amounts of time reviewing and working toward compliance of the revised standards which likely limit the amount of time available for person-centred initiatives such as MMD (S. Dupuis, personal communication, June 14, 2012).

2.5.5 Implementation Factors Summary

In summary, LTC continuing education or new programs can be successfully implemented when staff members are properly trained at a program designed to transfer their new knowledge into practice, leadership support is provided by the organization and all levels of management, and learning assistance and reinforcements are provided (Stolee et al., 2009). Resources in the form of staff, finances, and time in the context of flexible and supportive leadership can, therefore, foster a positive living and work environment where new learning and programs can be sustainably applied and encouraged.

2.6 Literature Review Summary

Since the majority of residents in LTC homes are older adults with dementia (57%), of whom 37% experience severe or very severe cognitive impairment (CIHI, 2010), they require staff trained to provide specialized care in order to meet their physical, psychological, and social needs. Research suggests that Ontario LTC homes are insufficiently funded and staffed which makes it difficult to provide residents with an appropriate level of care and quality of life (Dupuis et al., 2003; Sharkey, 2008; Smith, 2004; Stolee et al., 2005). This corroborates the findings that most residents with dementia spend the majority of their days in LTC alone, doing nothing, with few opportunities for social interaction, which negatively affects their well-being (Brooker et al., 2007; Cohen-Mansfield, 2000; Dupuis & Luh, 2005; Logsdon, 2000; Schreiner et al., 2005). Nursing staff in LTC tend to focus on the physical needs of residents by providing personal care and assisting with their activities of daily living, while recreation staff facilitate activities and programs which improve residents' physical functioning, interpersonal relationships, and cognitive engagement. Family members form an important part of the care team by sharing their knowledge with staff and continuing their nurturing relationship with their relatives by visiting frequently. Therefore, strong and supportive partnerships between residents, staff and family members in LTC are vital to ensuring a high quality of care for residents and quality of life of everyone involved (Dupuis & Norris, 1997; Dupuis & Pedlar, 1995).

The traditional biomedical model of providing LTC is derived from acute care that focuses on attending to and managing residents' physical symptoms and illnesses in

isolation from other aspects of their life (Dupuis, Wiersma et al., 2012; Kitwood, 1997; Wiersma & Dupuis, 2010). There has been a movement in recent decades to provide more holistic person-centred care that encompasses the bio-psycho-social needs of persons with dementia and their relationships with staff, family members and other residents in a meaningful manner (Brooker, 2004; Dupuis, Wiersma et al., 2012; Edvardsson et al., 2008; Kitwood, 1997; McCormack et al., 2010; McCormack & McCance, 2006; Nolan et al., 2004). The personhood of residents with dementia can be enabled by providing them with person-centred activities based on their roles, interests, needs and abilities, and using Montessori-based activities is an effective way to achieve this.

Montessori-based activities provide more structure, individualized attention, opportunities for interaction, and adequate sensory and cognitive stimulation for persons with dementia than regular large group activities (Camp & Mattern, 1999; Judge et al., 2000; Orsulic-Jeras et al., 2001) and can result in more positive effects on persons with dementia compared to regular activities (Camp & Mattern, 1999; Giroux et al., 2010; Judge et al., 2000; Orsulic-Jeras et al., 2000). Overall, engaging LTC residents with dementia using Montessori-based activities has been found to result in meaningful and enjoyable experiences that can be facilitated by staff or family members while decreasing behaviours such as agitation and social withdrawal, and lowering levels of fear, anger and anxiety experienced by persons with dementia (Camp et al., 1997; Camp & Mattern, 1999; Giroux et al., 2010; Jarrott et al., 2008; Judge et al., 2000; Orsulic-Jeras et al., 2000; Schneider & Camp, 2002; Vance et al., 1996). Montessori Methods for Dementia™ (MMD) is an educational workshop that anyone can participate in to learn how to provide

persons with dementia with Montessori-based activities so that their days are purposeful and meaningful (DementiAbility, 2012). The majority of MMD workshop participants are recreation staff who work in LTC homes (Elliot, 2011) likely because they are the main facilitators of activities for persons with dementia (Volicer et al., 2006).

Numerous reports have emphasized the importance of and increased funding required for activities and recreation staff in Ontario LTC homes because they are essential to enhancing residents' quality of life (Dupuis et al., 2003; Sharkey, 2008; Smith, 2004; Stolee et al., 2005). This is significant considering that LTC homes tend to involve residents in group activities which can be difficult for persons with advanced dementia to participate in (Giroux et al., 2010; Orsulic-Jeras et al., 2000; Volicer et al., 2006) despite the growing evidence that using an individualized approach beneficially meets the cognitive, emotional, physical and social needs and abilities of persons with dementia (Buettner, 1999; Gerdner, 2000; Giroux et al., 2010; Kolanowski et al., 2005; Orsulic-Jeras et al., 2001; Russen-Rondinone & DesRoberts, 1996; Van Haitsma, 2000; Van Haitsma & Ruckdeschel, 2001). Conducting mainly group activities for residents is likely due to the insufficient funding and staffing of LTC homes. Some of the barriers to implementing MMD identified by workshop participants are staff attitudes, lack of knowledge about the program and its benefits and effectiveness, the amount of time needed to implement the program, the costs and resources involved, and fear that it will contradict government regulations (Elliot, 2011). All of these barriers correspond with research done on factors that affect the implementation of continuing education and person-centred programs in LTC homes as there is no evidence on what affects the implementation of MMD in LTC

homes specifically, with only one study available on factors that can affect the

implementation of Montessori-based activities in LTC and other care settings (Skrajner et

al., 2007).

The study results reported by Michael Skrajner and colleagues (2007) involved

implementing Montessori-Based Dementia Programming® (MBDP) in a LTC home, an

assisted living facility, and two adult day centres in the Cleveland, Ohio area. This

observational study sought to determine: whether MBDP is an effective intervention for

dementia in different care environments; whether MBDP can be delivered on a smaller

scale and still be successfully implemented by staff; and the most important elements when

implementing a new programming method in a facility (Skrajner et al., 2007). The study's

participants were 52 persons diagnosed with dementia or who had a score of less than 23

on the Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975) and

completed all required data collection. Staff were provided with training and materials by

the researchers. MBDP staff education consisted of a three-tiered training structure

involving one-hour classroom sessions, "in-the-moment" trainings where participants

demonstrated and received feedback on implementing activities, and short monthly

meetings regarding creating and modifying current activities to be Montessori-based

(Skrajner et al., 2007). Evaluation tools were employed to ascertain whether staff were

implementing MBDP appropriately and effectively with participants as well as whether

MBDP was an effective and engaging intervention for persons with dementia (Skrajner et

al., 2007). The main outcomes from this study were: programs such as MBDP can be

implemented by staff in various facilities using short classroom trainings, demonstration of

program implementation methods, and evaluation tools, such as checklists; staff at all facilities were satisfied with MBDP implementation; it was crucial for administrators and staff from other departments, not just activities staff, to attend the training to increase staff buy-in within the facility; and MBDP implementation resulted in increased positive engagement and decreased levels of negative engagement in persons with dementia (Skrajner et al., 2007).

The present study intends to build on the work of Skrajner and colleagues by investigating staff perceptions of factors that affect the implementation of MMD in Ontario LTC homes. MMD is similar to MBDP as both teach staff working with persons with dementia how to create and implement Montessori-based activities, but MMD is different in that it is a two-day workshop which offers participants the option to become certified with more extensive practice using MMD techniques and principles and evaluation by a MMD expert (DementiAbility, 2012). Unlike the research conducted by Skrajner and colleagues, this study will focus solely on the perceptions of staff in Ontario LTC homes using an exploratory qualitative approach to discover and describe their views and experiences regarding implementing MMD activities with residents with dementia.

3.0 Rationale and Research Questions

3.1 Rationale

Research shows that Montessori-based activities can help address responsive behaviours experienced by persons with dementia by increasing their participation in and enjoyment of daily life. Due to the importance of engaging residents with dementia with Montessori-based activities in order to enhance their quality of life, and the absence of research on what affects the implementation of Montessori-based activities in LTC homes in general and in Ontario LTC homes specifically, the purpose of this study was to investigate staff perceptions of factors that affect the implementation of MMD in Ontario LTC homes.

3.2 Research Questions

Based on the political economy of aging theory, literature review and purpose of this study, the following questions were devised to guide the research:

1. What are staff's perceptions of the factors that affect the implementation of MMD in Ontario LTC homes?

2. What are the challenges that staff experience when implementing MMD in Ontario LTC homes?

3. What are the benefits that staff experience when implementing MMD in Ontario LTC homes?

4. In the opinion of staff, what are the benefits for residents with dementia and family members using MMD in Ontario LTC homes?

5. What are the supports available to or needed by staff, residents with dementia
   and family members who are using MMD in Ontario LTC homes?

4.0 Methodology

This chapter details the methodologies used to conduct this study. It begins by describing how participants were sampled and recruited, followed by information on the participants and where they worked, ethical issues, and interview procedures. The last section is on data analysis which included familiarity, reflexivity and field note journaling, memo writing, and thematic analysis.

4.1 Sampling and Recruitment

Purposive sampling was the sampling method employed so that respondents who best met the purposes of the study could be selected by the researcher in order to acquire information on the processes being studied (Neutens & Rubinson, 2002; Silverman, 2010). Study respondents were purposively selected for an interview from those who worked in an Ontario LTC home and who completed the MMD training taught in 2011 through the Gilbrea Centre for Studies in Aging. Only those participants who participated in workshops offered by the Assistant Director of the Gilbrea Centre were selected in order to standardize the content of the workshop. The rationale for sampling people who completed the training in 2011 was to obtain information on the experiences of those who recently completed the training so that they could more easily remember and report on their experiences as opposed to those who completed the training more than a year ago. Additionally, those who were trained in 2011 were more likely to be reached using the contact information they provided on their MMD registration form and still be working at the same location. Another consideration with purposively sampling participants from the

2011 MMD workshops was the researcher's feasibility of interviewing 15 to 20 participants over three months which was thought to yield sufficient qualitative data for analysis (Silverman, 2010).

The Assistant Director of the Gilbrea Centre had her administrative assistant send the initial contact email on her behalf to the selected MMD workshop participants letting them know that they had been invited to participate in the study. Her assistant sends all of the email notices on behalf of the Gilbrea Centre as well as to all MMD workshop attendees so potential participants had likely received previous emails from him which could help maximise the visibility of the emails regarding this study and prevent them from being marked as spam (Dillman, 2007; Sheehan, 2001). Inviting potential participants via email can be problematic as users tend to change their email address or email provider (Dommeyer & Moriarty, 1999), or have multiple email addresses – all of which can lead to sample bias and under-representation (Sheehan, 2001). As a result, email research invitations typically have an undeliverable rate of 19% (Dommeyer & Moriarty, 1999). The initial email included a recruitment letter and a letter of information that contained information about the purpose of the study, how their information would be kept confidential and that their responses would be used anonymously (Dillman, 2007). Potential participants were invited to respond by email or telephone to the researcher if they wanted to participate in the study or wanted more information about it. The researcher contacted those potential participants who responded to the email to provide further information and to determine if they would like to participate in the study, answer any questions, and schedule a time for a telephone interview. Upon agreeing to participate

in an interview, participants were emailed the interview questions at that time so that they could review them prior to the interview (Dillman, 2007). The Gilbrea Centre's administrative assistant also sent a reminder email about the study two weeks after the initial email was sent out as well as two weeks after the first reminder email was sent. Both email reminders included the recruitment letter and letter of information to ensure that potential participants were well-informed about the study (Dillman, 2007).

Participants were sampled from the Gilbrea Centre's list of those who took the MMD workshop in January, March, May, and August 2011 which comprised 194 attendees. An email was sent to all those who attended the aforementioned MMD workshops inviting them to participate in the study. Of the 194 selected MMD workshop attendees who received an email invitation to participate, 24 emails were returned as undeliverable (12.4%), and the researcher was contacted by 24 of the 170 potential participants. Of these 24 potential participants, the researcher determined that one was a full-time student, one worked in a retirement home, one worked in an adult day program, one worked in home care, and one worked in a mental health care facility. Since these five persons did not work in LTC they were politely advised that they would not be included in the study and were thanked for their interest. Of the remaining 19 potential participants who worked in LTC homes, all were interested in participating but five of them became unreachable to schedule an interview and one was not available the day the interview was scheduled. The researcher made two additional attempts to schedule or reschedule the interview with these potential participants but was unsuccessful. Thus, at the end of this process 13 participants agreed to be interviewed.

Aside from the 19 potential participants who were interested in the study after being contacted by the Gilbrea Centre, four other people heard about the study from colleagues and contacted the researcher about participating. One of them had taken the training with the Assistant Director during a month in spring 2011 that was not included in the original sample, two of them had taken the training with the Assistant Director in spring 2010, and one had taken the training with the Assistant Director in fall 2009. After speaking briefly with these potential participants, the researcher decided they seemed to have important insights that might inform the study, particularly since they were currently using MMD in Ontario LTC homes. Thus, consistent with purposive sampling, interviews were also conducted with these four individuals for a total of 17 interviewees (Neutens & Rubinson, 2002; Silverman, 2010).

Regarding compensation, potential participants were offered four complimentary copies of Montessori books designed for older adults with dementia, a $25 value, as compensation for participating. Compensation details were noted in the letter of information (Dillman, 2007). The reason for offering four copies of the same book is so that it could be read as part of a small group activity. Participants were offered a choice of the new Montessori book titles that the Gilbrea Centre published in fall 2011. Since two participants worked in LTC homes where residents primarily did not speak English, and the Montessori books are published only in English, they were offered a $25 craft store gift card so they could purchase Montessori materials which they gladly accepted.

4.2 Participants

As stated in Table 1 on the following pages, participants were classified into two groups: 'recreation staff' and 'consultants' as LTC staff members from other disciplines did not respond to the study's invitation email. The term 'recreation staff' will be used to denote those staff members who worked in the recreation/programs/activities department in a management or supervisory position, or were a recreation/programs/activities assistant in a LTC home. The term 'consultants' will be utilized to represent those participants who worked in various LTC homes as a regional manager/educator or as a regulated health care professional.

Table 1 – Demographics of Participants

Demographics of Participants	Recreation Staff (n=12)	Consultants (n=5)
Female Gender	12	5
Average Age	35.8 years	52 years
Education Level:		
University	5	4
College	7	1
Post-Graduate Diploma(s)/Degree(s)	4	4
Member of Professional Organization(s)	11	5
Taken Other Dementia Care Workshops or In-Services	11	5
Position in LTC Home Recreation/Programs Department:		
Manager/Supervisor/Director/Coordinator (R3, R4, R6, R7, R8, R9, R11, R12)	8	
Assistant (R1, R2, R5, R10)	4	
Consultant Position:		
Regional Manager/Educator (C1, C2, C3, C4)		4
Regulated Health Care Professional (C5)		1
Average Number of Years Worked at Current Company	5.8 years	6.7 years
Average Number of Years Worked in LTC	9.2 years	22.6 years
Percentage of Time Spent Directly with Residents	50%	27%

Table 1 - Demographics of Participants (continued)

Demographics of Participants	Recreation Staff (n=12)	Consultants (n=5)
Works in LTC Home(s) in LHIN Area:		
Southwestern Ontario	2	2
Central Ontario	9	3
Southeastern Ontario	1	
Northern Ontario		
LTC Home Size and Profit Status:		
Small Non-Profit/Charitable/Municipal < 150 beds	2	
Large Non-Profit/Charitable/Municipal 150 or > beds	3	
Small For-Profit < 150 beds	4	
Large For-Profit 150 or > beds	3	
Non-LTC Home Company Profit Status:		
Non-Profit/Charitable/Municipal		3
For-Profit		2
First Heard About MMD Through:		
Employer/Supervisor	6	2
Colleagues	3	2
Alzheimer Society/Psychogeriatric Resource Consultant	2	1
Nursing/LTC Magazine	1	
MMD Workshop Paid By:		
Employer	11	4
Participant	1	1
Took MMD Workshop:		
Fall 2009	1	
Spring 2010	2	
Spring 2011	5	3
Summer 2011	4	2

All of the participants were women. Consultants tended to be older (52 years on average) than recreation staff (35.8 years on average) and they also had a higher level of education (80% had a university degree) compared to recreation staff (42% had a university degree). All participants had at least one diploma and/or degree in a gerontology, human services and/or health sciences related field. The majority of

recreation staff participants were educated in recreation therapy, gerontology activation, gerontology social services, and/or developmental services (84%), whereas one participant had a nursing background (8%), and one was trained in religious studies (8%). Two consultants were educated in nursing (40%), one was trained in recreation therapy (20%), one had a social work background (20%), and one was an occupational therapist (20%). Most of the recreation staff interviewed were recreation managers (67%) while the majority of consultants were regional managers/educators (80%). All consultants were members of professional organizations, such as Ontario College of Social Workers or Registered Nurses Association of Ontario, while all recreation staff, except for one, were members of professional organizations such as Activity Professionals of Ontario or Therapeutic Recreation Ontario. All participants, except for one recreation staff member, had taken dementia care or other dementia related workshops such as Gentle Persuasive Approaches, U-First or a related Montessori introductory session. Recreation staff mainly took the workshops as part of on-site LTC in-services, while the consultants reported receiving education off-site such as P.I.E.C.E.S., Moira Jones' Gentle Care Strategies, or at gerontology conferences.

In terms of experience, consultants had been working a slightly higher average number of years for their current employer (6.7 years on average) than recreation staff (5.8 years on average), but they had more than twice as much experience working in LTC (22.6 years on average) than recreation staff (9.2 years on average). On average, consultants reported spending about 27% of their time working directly with residents, since they mainly worked with LTC staff, while recreation staff said they spent about 50% of their

time working directly with residents since most of them were in a management position. Generally, recreation assistants spent 91% of their time working directly with residents while recreation managers spent 29% of their time with residents.

The location of the LTC homes that participants worked in were grouped into four geographical areas based on the home's Local Health Integration Network (LHIN) area (LHIN, 2012). The Erie St. Clair, South West, Waterloo Wellington, and Hamilton Niagara Haldimand Brant LHIN areas will be referred to as southwestern Ontario. Central Ontario consists of the Central West, Mississauga Halton, Toronto Central, Central, Central East, and North Simcoe Muskoka LHIN areas. Southeastern Ontario refers to the South East and Champlain LHIN areas. Northern Ontario comprises the North East and North West LHIN areas. Seventy-five percent of recreation staff worked in the central LHIN area (n=9), with 17% in the southwestern LHIN (n=2) and 8% in the southeastern LHIN (n=1). As for the consultants, 60% (n=3) worked in the central LHIN area while 40% (n=2) worked in the southwestern LHIN. No participants worked in the northern Ontario LHIN area.

Regarding the size and profit status of the LTC homes participants worked in, 33% (n=4) worked in a small for-profit home with less than 150 beds, 25% (n=3) worked in a large for-profit home with 150 or more beds, 25% (n=3) worked in a large non-profit/charitable/municipal home with 150 or more beds, and 17% (n=2) worked in a small non-profit/charitable/municipal home with less than 150 beds. Sixty percent of consultants worked for a non-profit/charitable/municipal company (n=3) while 40% (n=2) worked for a for-profit company.

Participants were asked how they first heard about the MMD workshop, who paid for it, and when they took the workshop. Fifty percent (n=6) of recreation staff said they heard about the workshop from their employer or supervisor, 25% (n=3) heard about it from their colleagues, 17% (n=2) heard about it from the Alzheimer Society or a Psychogeriatric Resource Consultant, and 8% (n=1) first read about it in a nursing or LTC magazine. As for the consultants 40% (n=2) first heard about the MMD workshop from their employer/supervisor, 40% (n=2) heard about it from colleagues, and 20% (n=1) heard about it from the Alzheimer Society or a Psychogeriatric Resource Consultant. When asked who paid for their MMD training, 92% (n=11) of recreation staff said their employer paid for their training while 8% (n=1) said she paid for the workshop. Similarly, 80% of consultants (n=4) said their employer paid for their MMD training, with 20% (n=1) reporting that she paid for the workshop. As to when participants took the MMD workshop, 42% of recreation staff (n=5) attended the workshop in spring 2011, 33% (n=4) took the workshop in summer 2011, 17% (n=2) said they took the workshop in spring 2010, and 8% (n=1) attended the workshop in fall 2009. Sixty percent of consultants (n=3) reported taking the MMD workshop in spring 2011 with 40% (n=2) in summer 2011. None of the recreation staff or consultants who participated in this study took the MMD workshop in January 2011 even though it was one of the sampled workshops.

4.3 Ethical Issues

This study was reviewed and approved by the McMaster University Research Ethics Board. Consent was obtained from participants at the beginning of the interview where the first few minutes were spent discussing the details in the letter of information and obtaining oral consent which was recorded in a log. This study posed minimal risk to participants as no deception was involved, the research questions were not of a personal nature other than to gather some basic demographic information such as age and level of education, and all data compiled was made anonymous by using informant codes with no identifying information. All data regarding the participants and their responses to the interview questions remained confidential throughout the study by keeping the data on a password-protected computer and in a locked filing cabinet. After the study is complete, any identifying information will be destroyed by deleting it from the relevant electronic files, audio recordings, and/or paperwork. Any data reported in this master's thesis and subsequent dissemination of its results will be in aggregate form with careful attention to not include any quotes or information that could identify a participant or where she worked. As such, any data reported will be anonymous.

4.4 Interview Procedures

Semi-structured interviews were utilized during this study using a primary set of questions (Appendix A) from which the researcher asked other related questions using in-depth probing so that information from predetermined questions could be acquired with opportunities for further exploration (Neutens & Rubinson, 2002). The decision to

conduct the interviews via telephone was based on its relative ease, efficiency and cost-effectiveness compared to in-person interviews so that participants from across Ontario could be interviewed without the researcher having to take extensive amounts of time travelling between interviews or incurring travel expenses (Neutens & Rubinson, 2002; Silverman, 2010). Telephone interviews also enabled participants to remain more anonymous than in a face-to-face interview and are more convenient which could have increased participants' willingness to participate (Neutens & Robinson, 2002; Silverman, 2010). Semi-structured telephone interviews were conducted with participants from mid-September to mid-November 2011 to obtain their views and experiences. Participants were asked mainly open-ended semi-structured questions (Appendix A) regarding their experiences with implementing MMD in LTC homes. The questions were based on the findings of the literature review regarding the individual, program-related, organizational, and structural factors that could affect the implementation of MMD, as well as basic demographic information, and the participants' experience with any challenges or successes they encountered. Additional questions and topics were also explored as a result of journaling and memo writing where concepts from previous interviews were raised in subsequent interviews to provide the researcher with greater insight into the topic (Charmaz, 2006; Garrison 2011a, 2011b). These included sanitization issues with MMD activity materials, the use of lifelike dolls, how family members learn about and use MMD activities, the supportive or unsupportive attitudes of other staff members, staff budgets, and staff-to-resident ratios.

The length of the interviews ranged from 23 and a half minutes to an hour and 15 minutes depending on the breadth of the responses from each participant as well as their availability. The average length of each interview was 44 minutes. Each interview was recorded with permission from the participants, and typed notes were taken by the researcher concurrently during the interview in case the digital recorder failed. All interviews were successfully recorded and, as a result, the quality of the transcriptions was superior to the typed notes taken during the interviews.

4.5 Data Analysis

Data analysis of this research involved developing familiarity with the data (Charmaz, 2006), reflexivity and field note journaling (Charmaz, 2006; Garrison, 2011a, 2011b), memo writing (Charmaz, 2006, 2008), and thematic analysis (Braun & Clarke, 2006).

4.5.1 Familiarity

The researcher developed a close familiarity with the data since she was the one who conducted all of the interviews, transcribed them, and then verified and cleaned the transcriptions. Becoming immersed in the data enabled the researcher to obtain an awareness and understanding of the participants' experiences (Charmaz, 2006). The audio recordings were listened to during the transcription process where the interviews were individually played through Express Scribe Pro software using a reduced speed setting of 70% and a five second playback loop as they were typed verbatim into Microsoft Word. Their content was then verified by listening to each recording at regular speed while reading the corresponding transcript to ensure each interview was accurately transcribed.

Verifying the content of the transcriptions aided in ensuring the quality of the data before it was analyzed (Silverman, 2010). The transcriptions were subsequently cleaned by removing all identifiable data, such as names, titles and locations, before importing them into NVivo (version 9) qualitative data management software for coding and further analysis.

4.5.2 Reflexivity and Field Note Journal

Data analysis began after the first interview was conducted as the researcher typed reflexive and field notes in a journal. Reflexive journal notes were written immediately following each interview so that the researcher's thoughts, reflections, and reactions regarding herself, the participant, and the interview were captured at that point in time rather than retrospectively (Garrison, 2011a, 2011b). Specifically, the researcher's thoughts and feelings about how the interview went, and how the researcher's personal history, interests and assumptions may have influenced the interview and the participant were noted (Charmaz, 2006). After compiling reflexive notes, field notes were then typed to record the researcher's preliminary interpretations, connections to previous interviews, and links to literature review data (Garrison, 2011a, 2011b). The researcher's observations and comments regarding the context of the interview, such as the weather, time of day, the setting in which the interview took place, and whether there were any distractions for the participant and researcher, as well as the dynamics of the interaction between researcher and participant were also recorded (Garrison, 2011a, 2011b). Keeping a reflexive and field note journal was useful for noting how the interviews were conducted, the relationship between the researcher and participants, and how participants should be represented in

written reports (Charmaz, 2006; Garrison, 2011a, 2011b). Like memo writing, journaling

raised questions which were explored with participants in subsequent interviews.

4.5.3 Memo Writing

Memo writing for this study occurred at the beginning of data collection and was

on-going. It involved making notes of ideas in a file separate from the reflexive and field

note journal at any time during the research process where memos could be partial,

tentative, exploratory or pictorial (Charmaz, 2006, 2008). The memos then provided the

context for exploring and checking the data as well as creating and revising ideas,

concepts, and categories (Charmaz, 2008). Memos allowed the researcher to analyze the

codes and subsequent categories or themes that were initially developed and then further

redeveloped. This process assisted with shifting the researcher from describing the data to

the analytic process of exploring meanings, situations, actions and responses by raising

questions which could be answered through additional data collection in subsequent

interviews (Charmaz, 2006, 2008). Memo writing focused more on ideas and how the data

were and could be coded, whereas reflexive and field note journaling pertained to the

context of the interviews, how they were conducted and with whom, and the information

gained from them.

4.5.4 Thematic Analysis

Thematic analysis was the method used for analyzing the semi-structured interview

data in this study. It is a flexible and practical technique to acquire detailed and insightful

explanation of the phenomenon being studied. It enables researchers to identify, analyze,

and report patterns or themes in the data so that the data are not merely described, but are

also interpreted in relation to the research topic, question(s), and literature (Boyatzis, 1998; Braun & Clarke, 2006). Braun and Clarke (2006) provided a very detailed method for thematically analyzing qualitative data which is based on the process described by Boyatzis (1998). Braun and Clarke (2006) rigorously maintain the method's link to qualitative research whereas Boyatzis's method (1998) prepares qualitative research to be transformed into quantitative data, which is more suitable when using a mixed-methods approach. Braun and Clarke (2006) stressed the importance of actively describing the process of how the researcher identified patterns and themes, selected those which were most relevant or interesting, and conveyed their meaning to the reader so that other researchers can know how the data were analyzed and under which assumptions in order to evaluate, compare or synthesize it with other studies. Another useful feature of thematic analysis is that it can be used with virtually any theoretical framework (Braun & Clarke, 2006), and, as described earlier, it was used in conjunction with the political economy of aging in this study. This theoretical framework and method of data analysis provided a means to explicate, describe and explain the accounts and insights of the factors that affected the implementation of MMD in Ontario LTC homes which will be further examined in the Results and Discussion sections.

The researcher began using the thematic analysis method advocated by Braun and Clarke (2006) during data collection which continued with the writing and reporting of the themes and their meaning in relation to the research topic, questions, and literature. Thematic analysis was an on-going and recursive process where the researcher continuously shifted back and forth between the complete data set, coded portions,

memoing, and the analysis of them (Braun & Clarke, 2006). Braun and Clarke (2006) emphasized that writing is a vital part of the analysis as it too starts in the first phase while the data is being collected and continues until the final report is complete. The researcher did this by compiling a reflexive and field note journal as well as writing memos during data collection and throughout the analysis (Charmaz, 2006, 2008; Garrison, 2011a, 2011b).

Braun and Clarke's (2006) guide to thematic analysis comprises six phases which were applied to suit the research questions, method of data collection, and theoretical framework (Patton, 1990). The researcher familiarized herself with the data during the first phase by transcribing the data, verifying it, cleaning it and then reading and re-reading it while noting initial ideas (Braun & Clarke, 2006; Charmaz, 2006; Silverman, 2010). Data from the interview transcripts were manually sorted using NVivo into 9 initial categories with 62 subcategories based on the thematic topics of the questions. The initial categories as per the order of the interview questions were: Experience in MMD workshop; MMD resources purchased; History of MMD at LTC; Using MMD at LTC; Barriers or challenges to implementing MMD; Facilitators to implementing MMD; Finding support; Changes or results since implementing MMD; and Other comments.

The second phase involved generating initial codes using NVivo by coding interesting aspects of the data from the initial categories line-by-line in a systematic manner across the whole data set while also compiling data relevant to each code (Braun & Clarke, 2006). This is where preliminary general and specific codes were created by the researcher. The data from the 9 initial categories were manually collapsed using NVivo

into 7 initial codes with 43 subcodes based on the researcher's memoing and journaling. The initial codes in alphabetical order were: Connecting; Finding Support; Educating and Understanding; Improving Quality of Life; Ministry of Health and Long-Term Care Regulations; Need for New Activity Ideas and Interventions for Residents; and Seeing is Believing.

Searching for themes comprised the third phase where codes were collated into potential themes and relevant data were gathered for each potential theme using NVivo (Braun & Clarke, 2006). A preliminary code manual was devised at this point to aid in organizing the data and analyzing it. The data from the 7 initial codes were manually collapsed using NVivo into six initial themes with 22 subcodes based on the researcher's memoing and journaling. As a result, the initial themes Need for New Activity Ideas and Interventions for Residents, and Improving Quality of Life were merged into the theme Quality over Quantity. The initial themes in alphabetical order were: Connecting; Educating and Understanding; Finding Support; Ministry of Health and Long-Term Care Regulations; Quality over Quantity; and Seeing is Believing.

Themes were reviewed during the fourth phase by checking if the themes coherently matched both the coded data extracts and the complete data set (Braun & Clarke, 2006). This was followed by creating thematic maps and pictorial memos of the analysis so that the patterns and relationships within the data, as well as the researcher's analytical thinking, could be viewed in a visual format (Braun & Clarke, 2006; Charmaz, 2006). This greatly aided in structuring the themes hierarchically and identifying the relationships between them. The code manual was also revised at this stage. The six

initial themes remained the same but were organized hierarchically and the subthemes were manually collapsed using NVivo into 21 subthemes. The researcher then met with her supervisor to identify whether the codes and themes were accurate, and the code manual and thematic content were subsequently revised. The same six initial themes in hierarchical order were: Ministry of Health and Long-Term Care Regulations; Educating and Understanding; Seeing is Believing; Finding Support; Connecting; and Quality over Quantity.

The fifth phase entailed defining and naming themes by refining the specific aspects of each theme as well as the general account of the analysis by creating clear definitions and titles for each theme (Braun & Clarke, 2006). This was done in consultation with the researcher's supervisor and thesis committee where the code manual and themes were then revised accordingly so that the thematic titles more compellingly and clearly captured the essence of each theme. Most themes were renamed while one theme, Quality over Quantity, was divided back into two themes in order to more accurately portray why and how participants transitioned to using MMD activities (Shifting Practice Amidst Resistance to Change) and the positive effects that MMD had on residents' quality of life (Improving Residents' Quality of Life). More supporting data were then added to these two themes. This process resulted in 7 final themes with 21 subthemes in four categories of Limiting Factors, LTC Culture Change Tensions, Enabling Factors, and Positive Outcomes. The final themes as per the four categories are as follows: Limiting Factors: Regulating and Funding Medical Practices (formerly Ministry of Health and Long-Term Care Regulations). LTC Culture Change Tensions: Shifting Practice Amidst

Resistance to Change. Enabling Factors: Educating and Understanding; Seeing Results is Believing (formerly Seeing is Believing); and Being Supported (formerly Finding Support). Positive Outcomes: (Re-)Connecting People and Passions (formerly Connecting); and Improving Residents' Quality of Life.

The final phase involved the production of the report where the researcher selected vivid and compelling examples from the data and analyzed them in relation to the research questions, literature and theoretical framework so that a scholarly draft report was the end product (Braun & Clarke, 2006). The draft report was subsequently revised in consultation with the researcher's supervisor and thesis committee in order to produce the final copy of this master's thesis.

5.0 Results

As a result of the thematic analysis, 7 themes emerged from the data: Regulating and Funding Medical Practices; Shifting Practice Amidst Resistance to Change; Educating and Understanding; Seeing Results is Believing; Being Supported; (Re-)Connecting People and Passions; and Improving Residents' Quality of Life. These themes and their subthemes are described in this chapter. From this section forward, note that residents with dementia will typically be referred to as 'residents'. Regarding the labelling used for quotations, recreation staff are identified with 'R', consultants are denoted with 'C', and the interviewer/researcher is indicated with 'I'.

5.1 Regulating and Funding Medical Practices

This theme includes participants' views on how Ontario Ministry of Health and Long-Term Care regulations affected the implementation of MMD and staff attitudes toward it as well as the financial resources available to staff for activities, training and human resources. Ministry regulations reinforced a biomedical model of care rather than a person-centred one as the medical needs of residents were given priority over their quality of life. This was reflected in the staff hierarchy participants observed with nursing staff and related duties being more significant than recreation staff and activities, likely due in part to the participants being primarily from recreation. Subthemes to be discussed include: Ministry Regulations Help Create Medicalized and Task-Oriented LTC Practices; Medicalized LTC Leads to Staff Hierarchy; and Limited Ministry Funding.

5.1.1 Ministry Regulations Help Create Medicalized and Task-Oriented LTC Practices

Staff in LTC homes were driven by Ministry regulations which structure how they work. Ministry regulations allegedly encouraged nursing staff to use a task-oriented approach when working with residents rather than a person-centred approach due to time restrictions and a fear of repercussions experienced by staff. As a result of the medical structure of LTC, participants reported that the medical needs of residents take priority over their quality of life which can make it challenging to implement programs such as MMD and ensure their sustainability.

5.1.1a LTC staff were driven by Ministry regulations

Staff in LTC must follow Ministry regulations in order to maintain the home's funding and to avoid being internally and publically sanctioned by Ministry inspectors. Participants gave examples of some of the regulations that staff adhered to. One participant described how all staff must follow Ministry regulations, but that nursing staff were particularly driven by them and did not let residents assist with daily activities, like making a bed, out of fear that inspectors would disapprove:

> R11: Some of the barriers [are], you know, nursing being task-orientated and thinking that the Ministry is not going to allow for this. Everybody's nervous, you know, and I'll just say in our area is a lot of [ethnic] residents and they're very household driven, they like to do household chores. So that would take over some of our staff's chores if they allowed them to, but they're so nervous of the Ministry.
> I: So they're worried that they're going to get in trouble if they let residents take over some of the chores?
> R11: Yes. Like if they make the bed and not do it correctly. I know that they're driven by the Ministry of Health, and so are we, but if they don't make the bed properly they figure if an inspector comes in and trying to explain that would just be, you know, way harder than just doing it themselves.

Likewise, another participant explained why nursing staff did not allow residents to help

with daily chores as she thought it would not be in accordance with Ministry requirements:

> *R2: ... it stems from, you know, staff needs, hours of service, how they document what they do with their time, how fast things have to get done, their schedule, so you know, keeping to the Ministry of Health standards, you know, so many people have to be toileted and bathed and everything else.*

In addition to meeting standards, a consultant described how the recent transition from

previous legislation to the new Long-Term Care Homes Act has presented challenges for

staff:

> *I: ... what do you think are some of the main barriers or challenges that you encounter when trying to implement the program into long-term care homes? C2: Um, the pace, everything goes so slowly mainly because they have so many things to deal with on a daily basis and now with the Ministry with ... the introduction of Long-Term Care Act, they have to do so many things differently, however their internal structure has not changed, the internal structure and dealing with all these changes and they're still doing it based on the old structure. Internally also they have to move, they have to learn how to do business differently and because they have to work with the workforce they have, who have been there forever, and used to the old way of doing things, these new things are taking a long time for them to cope with.*

5.1.1b Nursing staff were task-oriented

Participants also reported that nursing staff tended to be task-oriented in the way

that they cared for residents which made it difficult to implement MMD since they were

unwilling to change their approach by incorporating some Montessori principles or

activities. One participant (R7) described the task-based approach to care by nursing staff

as follows*: "in long-term care there's such a routine, a rigid routine, like meals are this*

time and bath is this time and, you know, personal care is this time." A consultant who

persuaded nursing staff in one LTC home to use MMD activities found that:

> *C1: ... they work more as a group instead of, you know, just instead of being task-oriented and getting the residents up and ready for the day and for meals that there's activities that they can actually enjoy with them.*

Therefore, the nursing staff in that home were able to transition from a task-oriented practice to a person-centred one using MMD. Another consultant reported the difficulty she encountered when trying to encourage nursing staff to use MMD principles and activities. Nursing staff were opposed to changing their routine:

> *C5: Staff buy-in is another problem where, you know, I go in and I say, "I would like you to try this." And they're like, "Well, I have to get eleven people out of bed. I'm not doing that for him." Right? It's a very task-oriented work environment and so to add something that is sort of unique or a little bit out of the box is threatening to some of the staff, especially those who have been there forever, and in their words, have seen everything and nothing works kind of thing. So staff attitudes is a big deal.*

Similarly, a recreation manager anticipated that one of her greatest challenges with implementing MMD throughout the home was changing the work habits of nursing staff and that she would seek advice from consultants on how to educate them:

> *R11: What I think our biggest challenge will be in the next few months is training everybody, is getting PSWs on board ... So I'll probably be calling people in for consultations on how to do the education with these people who are so task-oriented.*
> *I: Right, right, so for the PSWs and the nursing staff?*
> *R11: Yes. I hate to label, but. {chuckles}*

5.1.1c Medical priority over quality of life in LTC

Participants noted how the medical needs of residents in LTC homes were given priority over their quality of life. Most residents had complex needs that nursing staff and the home's administration focused on, which presented challenges for recreation staff to implement programs like MMD. A consultant described the situation in LTC as:

C5: ... you want to do all these neat things but then it's flu shot time and that's all they can think about. So there's trends in the home that will cease programs on the dime. So right now we're battling that everybody has to have the flu shot and then come January-February we're going to be on outbreak and have flus, so there's those real life situations that really impact programming, any programming whether it's Montessori or just regular activity programming ... it's just the nature of the environment ... I see buy-in until the flu season comes and then they forget everything. {sighs} Honestly, that's what happens.
I: Mhm. Cuz then I guess the medical needs end up taking priority over everything?
C5: Well then everybody's functional status changes ... we've got the most people with the most diagnoses all under the same roof. So there's all of those barriers too, the medical diagnosis, the physician changing the medication on every visit, so I mean the needs are complex. I'm just happy that some parts of this are successful.

Another participant concurred that altering the medical nature of LTC is challenging:

R12: We're just dealing with a primarily medical environment, right? And, while even the government's trying to get away from that it's hard, when you know, you're dealing with people who have been in nursing for 20 years and suddenly be open to this whole other way of nursing.

Having staff view the needs of residents primarily from a medical perspective influenced how they cared for residents. A consultant (C2) commented on how nursing staff approached responsive behaviours from a medical perspective: *"behaviours are presented but they're looked at as behaviours that need to be treated rather than looking at what causes these behaviours."* Another participant also found that nursing staff tended to view responsive behaviours as requiring medical intervention rather than as a means to improve the resident's quality of life:

R11: ... psychogeriatics teaches us, most of us in school, in the activation department, that you know, none of these drugs have ever been tested much and especially the mixtures of drugs, you'll always hear doctor in a care conference add or subtract a drug but, you know, I always hear them saying, "Well, now that's OK to take Lipitor and take this one and that one, there is no real effect." There is one. It's so toxic. And we know that, and sometimes there's hardly any solution beside restraints, you know? Drug restraints or tying them up, because they think

that the behavioural is not changeable but I know it is. It's through Montessori with more staffing. {chuckles}

5.1.2 Medicalized LTC Leads to Staff Hierarchy

The medicalized nature of LTC seems to create a staff hierarchy where nursing staff are superior to recreation staff. This hierarchy was reflected in participants' responses as they commented that nursing staff did not respect recreation staff or understand the value of programs, nursing staff did not participate in or help implement programs that were initiated by recreation staff, and nursing staff respected consultants' 'expert' suggestions.

5.1.2a Disrespecting and undervaluing recreation and MMD

Participants commented on how nursing staff generally did not respect recreation staff as professionals and they did not understand the value of using programs such as MMD for residents. One participant described nursing staff's reluctance as being due to their disregard for the recreation department:

> *I: And then what were some of the barriers or challenges that you encountered when trying to put the Methods into practice there?*
> *R10: ... getting everybody on board, you know, getting nursing on board, saying that it's was a valuable exercise.*
> *I: OK, so they were reluctant to support it to start?*
> *R10: At first they were, yep. And still there are people that still think it's not great ... it's just, you know, I think it's more of a lack of respect for the department, like recreation as opposed to the Montessori.*

Another participant also found the attitudes of nursing staff to be the greatest challenge when implementing MMD:

> *R6: Nursing staff and our personal care providers, um they may not have the same views as we do and think that it's actually useful and helpful. So I think it's going to be a long road trying to bring them on board as well with using Montessori not just in recreation but in everyday things.*

Similarly, one recreation manager described the attitude that some nursing staff had toward

activities and recreation staff and how it affected small group programs like MMD:

> *R11: You know, even if, no matter which program you start here it's always been*
> *that nursing will just start, you know, you're in one little room and they, for some*
> *reason they start filling in 10 people that they've been having problems around the*
> *nursing station with. So that doesn't work for Montessori, and it's never worked*
> *for therapeutic [recreation] and it's really up to the individual staff to be very*
> *voiceful and have their signs up, and telling nursing, "No you can't do this. This is*
> *not for them."*
> *I: Oh OK, so even when they're trying to do some of the smaller programs with*
> *residents they end up bringing in other people?*
> *R11: Yep. You know, "Mrs. Smith is yelling out here and she said she wanted to go*
> *in." Even though she's someone who never talked before. {chuckles} ... And I hate*
> *to say the old fashioned nursing, but it seems to be the ones from the old school*
> *who truly believe um any activity is usually babysitting, and it's not. They're*
> *getting better, I have to say, but there's a few that still think that way.*

Some participants described what they believed was the source of nursing staff's lack of

respect for recreation staff and activities. According to a recreation manager:

> *R12: I think the root of it though is, in general ... we aren't regarded, at least not*
> *in Ontario, we're not seen as sort of a profession, and professionals, even though*
> *we do have a certain level of education and such as everybody else, and I think*
> *that's the root problem is that we um, anything that we bring forward is not*
> *regarded on the same level as a medical professional, or a nurse, or whatever*
> *because they just don't regard us in that same level. And that's an on-going*
> *struggle, we're always fighting for ourselves in this environment as being*
> *multidisciplinary, I guess, as being regarded as just as important in a resident's*
> *quality everyday life as the nurse, as the doctor, as the medicine, as, you know? So*
> *we already are facing that and constantly advocating for what we do, so to really*
> *put something like this [MMD] out there, {chuckles} it's another struggle in our*
> *profession.*

This point was corroborated by a consultant who had been trying to improve the attitudes

of nursing staff toward recreation staff in LTC:

> *C5: My heart goes out to the recreation staff because it seems they really just lack*
> *credibility with the nursing staff. It's still that age old thing like, "I'm going to*
> *page the rec staff because someone's bored and get them to take them to tea time."*
> *Or something like that ... They put them lower down on the totem pole,*

unfortunately. I'm not saying it's right but it's been going on forever ... I think the rec staff know what they do but I don't know that in their training they have that extra level of understanding the medical side of things, so sometimes that's where the downfall is ... And so over my years when I've been consulting to the recreation department, it's even simply changing their language or understanding a diagnosis more because if you ask an RN to explain what's going on medically they're happy to share it, but I think the rec staff get scared ... the nurses can be really kind of, they can talk down to them, so I understand their fear too.

5.1.2b Unwillingness of nursing staff to participate in recreation programming

Participants provided numerous examples detailing how nursing staff would not participate in MMD activities even for their own benefit. A recreation manager described how nursing staff would not participate in a Montessori activity to meaningfully engage a resident with repetitive requests:

R3: For me the biggest issue is the lack of willingness to participate from the nursing staff. Because um, for instance we have a situation here where we have a resident who's asking to go to the bathroom every 15 minutes and so we were asked to like do some kind of a program with her that was, you know, kind of a Montessori program in nature to help keep her busy and to reduce the behaviour and so that's great, but we only have so much time in our day and I don't think it's that hard for a nursing staff, whether it be the charge nurse, the PSW, or the RPN to kind of step in and help us to implement it. And they are completely unwilling ... even the supervisors won't help me to kind of share the responsibility ... to just sit them down and set them up with something so that they can be busy and be doing something that's productive when we're not there. But they won't do it. So for me that's very frustrating ... they want us to do everything, um which is hard because we're not there 24 hours a day seven days a week, we only work 6 days a week here, um and I have, you know, staff rotating on the floors so ... it would be great to be able to have the nursing staff, you know, step up to the plate a little bit because it's them that the residents are driving nuts if they're asking to go to the bathroom every 10 minutes, so if you just, you know, spend 5 minutes to help get them to do something then it will reduce that, but they don't understand that and they don't see it as their job.

Another participant reported success with using MMD activities to curtail responsive behaviours of a sexual nature with a male resident but found that nursing staff would not set up an activity for him:

> *R12: ... there were certain times of day where we knew that he needed to occupy his mind in other ways, and his hands, and ah whenever we would bring it out at these times, there would be no sexual behaviour. And then um, but then realistically again, we can't always be available like four or five times a days a day in a 12 hour day to do that, so we'd start leaving them in the home area, and the staff would see, they would see when we brought it, but they still, for whatever reason, could not make that connection that, "OK, I can give him the same thing." {chuckles} "They provided me with the tools, I just have to put them on the table the same as they did." And again, that seems to be where the disconnect is and realistically we cannot continue to provide it day in and day out for the rest of our lives when they're right there and they can do the same thing.*

Another participant also found that MMD was very effective in the dementia care home area she worked in but noted the challenge was the limited time available for recreation staff to implement programs whereas nursing staff were always there:

> *R6: ... it's hard because we only have, you know, three programs in there a day so it's the other staff that, the nursing staff and PSWs that are there with them all the time but we're having a hard time getting them on board to do these things with.*

A consultant (C3) reported similar challenges with trying to get the nursing staff to use MMD activities with residents. She commented that:

> *C3: ... everybody can do this, it's not just programming, PSWs can do these activities, the registered nurse when she's going by with the med cart can ... it's getting everybody's buy-in that they're all responsible. They really still think it's just programs' and recreation's job.*

5.1.2c Consultants given more legitimacy as "experts" by nursing staff

The unwillingness of nursing staff to use MMD either because they did not respect the advice of recreation staff or because they felt that their role did not encompass activities was ameliorated when consultants suggested they try using MMD activities. This is likely because nursing staff viewed the consultants as experts compared to the recreation staff. One consultant noted how nursing staff requested her assistance with creating activities as an intervention for residents:

I: And it sounds like you're saying that this is something that the nursing staff there, that they're willing to use the activities too or..?
C4: Yes, yes. And actually in all of those cases it was the nursing staff that called me in. I've had one case where the social worker called me in. So it actually hasn't been the activity departments, even though these are homes where I know the activity directors really well, it's actually been the nursing staff that have referred me, have sent me a referral.

She went on to explain that nursing staff were more willing to use MMD activities when they were recommended by someone who works outside of the home rather than by recreation staff:

C4: I think sometimes it's better to have an outside source come in and promote it. And then they see that it's something that the resident needs rather than something that the activity department is responsible for. You know in a nursing home or any institution it's always, there's always people that try and define who and what department does what, and a lot of times it's easier to say, "Oh, that's her job, not mine." But if I come from the outside, I'm hoping that the nursing staff will do it more. ... And the nursing staff that I've talked to have been very supportive about it. They really liked it.

Another consultant agreed that nursing staff respect the advice of consultants because they tend to be health care professionals or recognized as experts:

C5: ... yes they do respect the outside consultant coming in and saying, "How about we try this?" And then I take it to the rec staff or to the restorative care aide staff and they just find it's more credible under sort of a professional designate I think is what it is ... So when consultants come in, you're given that automatic respect because we're kind of starting, we're speaking the same language, right, whereas the rec staff aren't speaking in those same terms ... you have more credibility when you really know all about the diagnosis and how, say a UTI [urinary tract infection] can interfere with this strategy.

5.1.3 Limited Ministry Funding

Ministry funding regulations affected the ability of recreation staff to implement

MMD as they had limited money to purchase materials as well as hire and train staff.

Participants described the funding they received from the Ministry as insufficient to

provide quality programming, such as MMD, as they did not have enough financial or human resources to facilitate the small group or individualized one-on-one activities that benefit residents with dementia.

5.1.3a Insufficient funding for program materials

The ability of recreation staff to purchase materials for activities and programs like MMD was largely determined by the funding provided to them from the Ministry. Participants reported that the funding available to them for program materials was insufficient as they either had to slowly purchase items over time or request donations from family. When asked whether funding for materials or equipment was challenging, one participant (R1) replied: *"It's always an issue ... We're trying to make the best out of what we have."* Another participant also found that purchasing materials was difficult:

> *I: And were there any other barriers or challenges?*
> *R6: Um, probably just the cost of things and trying to put together our own kits and things like that, it's a slow road as well being able to go out and buy everything that we need.*
> *I: OK, and how do you try to address the challenge of dealing with a limited amount of money to try to buy things and put things together?*
> *R6: We definitely hit up the dollar store trying to buy, you know, cheaper items, um but really it's kind of out of our hands as far as the budget goes so we just have to try and make it work ... slowly buying things over time and building up a whole collection of things that we can use on a regular basis.*

When asked about the challenges they faced when trying to implement MMD, another participant also reported that it was difficult to buy materials and replace Montessori kits that went missing:

> *R12: ... one [challenge] we're having right now {chuckles} is we're like, "OK, we'll make these kits and we'll put them on the floor and the staff can use them, and blah, blah, blah." And then they all go missing, so suddenly, and you know, we really don't have a great budget, we don't have a lot of funding, and so we're having to replace these tools all the time.*

One participant reported that when she started to implement MMD, the lack of funding for materials limited the recreation department's ability to have a Montessori kit for each home area due to infection control concerns:

> *R1: ... when we started ... we didn't have at this time funds to have a Montessori kit at each floor, and with having sick people on the one floor using Montessori we thought without sanitizing it, it could carry, you know, all of the bacterias and viruses to another floor.*

A consultant (C5) corroborated participants' accounts of having to make a limited budget work with various activities, materials and infection control requirements. She suggested they look to other sources for funding or ask for donations:

> *C5: Absolutely, equipment and funding is a problem ... the activity department or the rec staff, they get so much per month, I think it used to be two hundred dollars a month to buy program supplies ... Sometimes the nursing restorative has some in their budget ... but certainly we do hear, "Well, we can't buy that this month." Or, "We can't buy that this year." Or, "You're just going to have to wait." So that's when we ask for volunteer support or families might consider buying a specific product for their loved one, um ya, we go to the resident council for support ... but um it's really going to other sources than the nursing home because they're always strapped.*
> *I: Ya, so you were saying that on average that the recreation department only has about two hundred dollars a month for residents?*
> *C5: That's probably old numbers, but ya, I think it's about that much for all the equipment they need ... And then you think of everything else they have to do and all the infection control protocols, like we can only use those squeezy balls so long before we have to toss them away, right, because what is maintained on the surfaces, and we have to test and see if there's a contagion that's sort of lurking on the ball. So those materials we have to really keep track of. And remember in the rec department it's not always just Montessori programming ... you have seasons where it's more about the outdoor barbeque or it's about the holiday season, entertainers ... so that all comes out of their budget.*

5.1.3b Insufficient funding for adequate staff-to-resident ratios

Ministry funding affected the ratios of recreation staff-to-residents in LTC since

LTC homes employ certain numbers of staff based on the funding they receive.

Participants reported that they typically had a very low staff-to-resident ratio which made it

difficult to provide residents with MMD activities as they work best on a one-to-one basis

rather than in a small or large group of residents. According to a recreation assistant:

> R1: We are usually not well staffed, so I cannot work with one resident only, I have
> a group of residents ... doing Montessori with up to 8 residents and in my case, all
> of them, they have behaviours and they have um, quite a, you know, level of
> dementia ... One-on-one, you know, it's not financially possible for facilities ...
> usually we are required to do group work. One-on-one we have as well but, you
> know, my employer wants me to do group work with my difficult residents and I'm
> really suffering. ... because each resident is different ... it depends on their interest.
> One would like to work with cards, another person want to do blocks and, you
> know.

Likewise, another participant also found that engaging all residents with dementia using

MMD activities on a one-to-one basis was not possible:

> I: And do you use it with all persons in your care or just some of them?
> R12: Um, the one-to-one sort of really intense programming, I would say, about 10
> percent. Because it comes down to those ratios and the time, however, we do try to
> apply it to all the programs, well OK, say 80 percent of the programming we
> provide. Um, so no not everyone, but the majority I would say yes in some facets.

Some participants mentioned that they began implementing MMD in their

dementia care home area where there was also a very low ratio of one recreation staff

member to 28 residents which presented its challenges. According to a recreation

manager:

> R7: ... our dementia unit is quite active right at the moment and at this point it's
> attention span and staffing levels. Because there's only one activation person to 28
> so ... if she's not monitoring for agitation or aggressive people then the person's

> *able to utilize the Montessori but it um, sometimes their role has to be different than programming.*

Likewise, another participant commented that the ratio of staff-to-residents in the dementia care home area was problematic:

> *I: ... what are some the barriers or challenges that you've encountered when trying to put the Methods into practice there?*
> *R8: I think it's just, um, time is another thing. Another challenge is if you got one resident doing Montessori and you've got 28 other residents not in Montessori, staff are saying, "Well why aren't you engaging these other residents?" And so I guess it's also a time factor and a staffing factor, but you can only do what you can work with.*

Some participants expressed the desire to have more recreation staff so that they could provide MMD programming to all residents who would benefit from it. According to one recreation manager:

> *R9: The more residents we add the more it becomes a challenge to the program.*
> *I: OK. And do you have any ideas for how you would like to ideally overcome this barrier?*
> *R9: Hrm, more staff.*

Another recreation manager similarly responded:

> *I: So how are you thinking of overcoming some of these barriers?*
> *R8: I think if, in an ideal world, more money in the budget to have another staff just doing Montessori all the time but again, I have to be realistic {chuckles} and that may not be possible.*

Other participants mentioned that more funding for recreation staff would ameliorate the difficulties they had with providing quality activities such as MMD and facilitate social interaction with residents:

> *R2: ... unfortunately in long-term care facilities the [resident-to-staff] ratio is quite large. There is a lot of clients to a staff person and hopefully in time that will change and there'll be more recreation activation staff that can do more work with seniors [with dementia] because often the more severe seniors are left out and um, you know, the mild to moderate seniors are worked with ... another issue is just the*

> *funding and acknowledgment of the importance of socialization for seniors and giving them tasks, giving them meaningful tasks to occupy their time. ... we need to have more staff so you can have a closer ratio of staff-to-clients.*

One recreation manager (R11) who had been working in LTC for many years noted that the low ratio of recreation staff-to-residents had not changed due to stagnant government funding: *"I've been in the field for 13 years and that was supposed to change and it never has."*

5.1.3c Insufficient funding for staff training

Aside from difficulties due to insufficient Ministry funding to purchase materials and have enough recreation staff to provide activities, participants also noted that they did not have an adequate budget for staff training. Participants remarked how they thought that sending all of the recreation staff to the MMD workshop would be very useful but that it was not possible due to budget constraints. According to one participant (R4): *"I think some of our barriers here are more financial barriers because I think it would be beneficial to send more staff to the workshop but financially that's not feasible."* A recreation assistant similarly agreed:

> *I: ... in terms of any structural or organizational challenges that you faced when trying to put the Methods into practice, I know you said that costs seems to be one of the main issues, so is that more in terms of the materials and ability of the home to train other people or..?*
> *R5: That is definitely a factor because ... we have six people in our department and they couldn't afford to send every one of us.*

One recreation manager thought that sending nursing staff to the MMD workshop would be an effective way to educate them but realized that it was not possible for all staff within the home to be trained:

> *R12: I know that our nursing department could not afford to send all of our front line staff for this education, but I think it's just important for them, especially the personal support workers, to be exposed to this sort of a workshop because it's such a great way for them to um, deter certain behaviours or just overall for the care that they provide ... and even my restorative care aides that I oversee, um she or he is generally a personal support worker or a registered staff, like an RPN, and I try to send them, I try to, but I've sent two in the past to this workshop, and them coming from that personal support work world and then going to this it's amazing what, how they see the light. But that's just one and there's like 200 staff here, {chuckles} so.*

The same manager noted that her ability to send recreation staff for MMD training was based on Ministry funding and regulations for educational purposes:

> *R12: ... it was actually one of our regional leaders in our company that told us about this Montessori Methods for Dementia workshop, so I, and we have down spending every year. {chuckles}*
> *I: Oh, what is down spending?*
> *R12: Down spending, basically throughout the year you maintain your monthly budget for your department, you're given an envelope and you have to stick within that budget on a monthly basis and then near the end of the year, usually like October/November, you're told sort of what um, what, where you stand in that year in terms of maintaining your budget and if you're under, whatever money you're under you have to spend and spend very soon or it will be deducted from your budget the following year and you never want that to happen. So that year I waited until there was one around down spending time so I could send myself and two of my staff at that time, to the two-day workshop.*

Consultants also mentioned how it was difficult for LTC staff to attend the MMD workshop due to budgetary issues. Regarding challenges with having nursing staff trained, one consultant remarked:

> *C1: ... when it comes to having some of them Montessori trained just cuz money is kind of tight lately with different organizations that maybe they wouldn't be able to afford to send too many of the front-line workers to be trained.*
> *I: OK, so I guess that's just a matter of the budgets at the individual long-term care homes?*
> *C1: Mhm, unfortunately, but.*

Another consultant also commented that it is not possible for many LTC staff to attend the

MMD training:

> C2: I've been sending any email that I'm getting about Montessori training going
> on here and there, the next one in [city name], I've been sending it to all the DOCs,
> the directors of care, so that they could fund some people to go, if not a lot but at
> least one in each organization. But I think the cost is a problem for them.
> I: OK, and so that's to attend the full two-day workshop?
> C2: Ya, ya. That's, cost is a problem for them.

5.1.4 Regulating and Funding Medical Practices Summary

In summary, the Ministry of Health and Long-Term Care's inclination toward

Regulating and Funding Medical Practices greatly affected the ability of recreation staff to

implement MMD. Ministry regulations reinforced the importance of meeting the medical

needs of residents at the expense of other aspects that improved their quality of life which

led to nursing staff being regarded as more essential and important than recreation staff.

Nursing staff reportedly viewed residents' needs and behaviours from a medical

perspective while recreation staff tried to facilitate residents' desire to engage in

meaningful activities and roles. Insufficient funding for adequate staffing levels, materials

and education also limited the ability of recreation staff to put MMD into practice.

5.2 Shifting Practice Amidst Resistance to Change

The theme Shifting Practice Amidst Resistance to Change refers to how MMD

activities are meant to provide quality, meaningful activities in a small group or one-on-

one format as opposed to traditional programs which aim to involve large numbers of

residents. It also explains how recreation staff transitioned to smaller more effective

quality programming in their LTC home using MMD, and the resistance they received

from staff and family members. Subthemes to be discussed include: Transitioning to

Smaller More Effective Quality Programming; and Encountering Resistance to Change.

5.2.1 Transitioning to Smaller More Effective Quality Programming

Recreation staff revealed how they transitioned from the traditional large group

activities format to smaller groups or more one-on-one MMD activities that best meet the

needs of residents. Some participants described why traditional programs were not

effective or suitable for residents with dementia. According to a recreation assistant:

> R2: ... programs where you have ten seniors with Alzheimer's or different
> dementias all trying to do one task that the leader is running and it is completely
> counterintuitive because in their own worlds, they are not in your world, so how is
> the program going to be successful, how are they going to enjoy it, how are they
> going to be at ease?

Another participant also realized that large group activities, like bingo, typically did not

meet the needs of some residents with dementia due to their varying levels of ability and

attention spans:

> R5: I've been trying to make things more accessible and trying to find the actual
> therapeutic value of certain programs. Like we have a bingo program for instance
> ... we have a lot of people that go to a bingo once a week and I don't see the use in
> it because, for some of the residents, because they're not getting any therapeutic
> value from it. They're not getting the cognitive aspects because they either can't
> hear the number that's called out or they can't see the number, the groups are too
> large ... normally our programs run for at least a half hour to 45 minutes when we
> do a group program ... but you can't do them for that 45 minute time because the
> attention span just isn't there. So what I've been doing is I've been breaking down
> the groups into smaller groups and focusing more specifically on the residents'
> needs and doing say, like sometimes it's been a five minute program and sometimes
> it's been a 15 minute program ... And I've just found that it's been a lot easier to
> break it down into smaller groups because then you get the true attention and the
> true participation from the residents that you're gearing it towards specifically.

Likewise, a recreation manager found that it was necessary to change the way she and her staff had previously provided activities to residents in large groups after introducing MMD into their LTC home:

> *R12: … one of the things we did in the beginning implementing all of this was to stop doing all the big socials, the big large group, pile everyone in a room programs, and scale down to more small groups or one-to-ones.*

Regarding how they transitioned from large group to small group or more one-on-one activities, recreation staff described how they typically started by implementing MMD with a few residents and then expanded the program from there. One recreation assistant stated how her home began using MMD by slowly and easily changing their regular one-to-one visits with residents to Montessori-based visits:

> *R10: … we already had a list of people, residents that we felt needed one-to-one visits, and so we were able to easily start visiting them with a Montessori package, you know Montessori activity. And we found it to be, it worked very smoothly for us … the residents are very receptive to it so that's what obviously spurred us on to continue with it. We received positive results from it. … it was easy for us just to say, "OK let's start with just two people." We started slow, we started with two people we switched over to Montessori as opposed to a simple one-to-one, and then we added, you know, four then six then eight, and we grew until we're at our capacity for our number of staffing hours that we can see these people.*

A recreation manager explained the process that her LTC home used to implement MMD by meeting with her staff to decide which residents would most benefit from it, and then started measuring residents' response to the activities to ensure it was a positive experience for them:

> *R4: … so when we first started it was a matter of we, you know, went around the home and said, "OK, who do we think would benefit from these programs?" Um, looking at mainly their diagnosis and what level and process through the dementia they were and then looking at, "OK, out of now, out of all the residents that we have selected that we think would benefit from this program, it's gonna be trial and error." … so we did a tracking tool … each resident had a sheet and first we*

started one resident off and we would do a sorting activity and then we would document their response to that sorting activity and how long that they could, were engaged in it. And then, ... "OK, well they did sorting and were successful at that." I would go on and try another activity and so now we have a baseline of what has been successful with some of our residents so we kind of know to try those things first. Then in turn keeping that evaluation process going so that we don't just stop at that because obviously we know that just because something's successful today doesn't mean that it's gonna be successful tomorrow, but at least we have a baseline so if their response ... caused a very high increase in responsive behaviours those are like the last things that I'm gonna try with that resident.

Similarly, another recreation manager (R3) slowly started putting MMD into practice in

her LTC home by discussing with her staff which residents would be best to use

Montessori-based activities with. She also described how the use of MMD throughout the

home grew based on the results they witnessed and the involvement of volunteers to help

facilitate more one-to-one activities with residents:

> *R3:... we talked about who would be good candidates on their floors of the people that they already work with and they're familiar with and about why they were good candidates for Montessori and then talking about, like which of the activities that we could do with them. And then I said, "Pick one person for now and focus on one person." And then they would do the program and see if it worked or not and it's kind of grown since then. Now they actually do a one hour program where they pair up a volunteer with a resident and then they show them what the activity is and let them do it with them.*
> *I: Oh OK. So your staff have been getting some of the volunteers trained in order to do more one-on-one activities or..?*
> *R3: Ya, so they would have, like instead of having a one hour program where they have 20 people attending a music program they would do a one hour Montessori hour and would have um a volunteer paired up with a resident and they would show them what the program was. So like if it was a sorting program then they would tell, show the volunteer what they needed to do with the resident and then they would sit down with the resident and do it so that the staff can have more than one person going on at the same time.*

5.2.2 Encountering Resistance to Change

Participants also recounted the reactions that they received from other staff and family members when implementing smaller group or one-on-one Montessori programs. According to participants, some of their recreation staff colleagues were reluctant to engage residents using small group programming because they were taught that a large group format is best. A recreation assistant explained the difference between the quality therapeutic programs she tried to implement and the large group social activities her co-worker favoured:

> *R5: I'm looking at the therapeutic value of the programs that I'm trying to do, whereas she's in the old mentality of ... getting the numbers [of residents] and getting the social aspect of it. She's very pro for that bingo group that we have ... this big bingo that we have to have four staff helping out at because there's too many people.*

Likewise, a recreation manager found that even some of her fellow recreation managers thought it was best to have as many residents involved in a program as possible rather than trying to personalize activities for residents. Here she described her plan for transitioning to more MMD activities in her home:

> *R11: ... people still wanna put big programs on and still get that big theory, you know? So hopefully in January it will be the smaller, individual Montessori programs and people will start understanding the difference between big and small ... even some of our programs managers have this mindset of, you know, "There was 20, wow I got 25 people in that group!" I came from I guess part of the later part of graduations and I've always known that it's never been about quantity, it's always been about quality, and I have groups with maybe 10 in and then always found I had to give them one-on-one [activities] no matter how high functioning they are. Everybody wants you to be personalized, everybody wants you to think of them as just a person, and Montessori does that, brings you back to that.*

Another recreation manager explained the reaction she received from nursing staff as she

and her staff transitioned to smaller Montessori programs for residents as they were used to

large group programs being held:

> *R7: Nursing staff have so much that they need to accomplish in a shift that they were, they wanted to see large group programs, they wanted to see, you know, everybody involved and that's not the, I mean, you can't do that the Montessori Method, that's not what it's um, so to help them understand that, you know, "This area, we're going to do this with these people right now, and then in 10 minutes.." The small programs of short duration is hard for people to buy into because we've always been, you know, {chuckles} big group, get them all involved, and then the activation that's what you're supposed to do. So to get that buy-in from, just to change that expectation of staff.*

Similarly, another recreation manager described how families reacted when her staff began

to switch the majority of their programs from large groups to smaller Montessori-based

activities in order to best meet the needs of all residents:

> *R12: ... we did receive a lot of resistance from certain families because they expect to come in, and the program staff have someone playing a piano and everyone's singing and dancing and piled in a big room all the time. And it's recognizing that do you do that in your own life? Like, do you do that every day? ... we have pub night once a month, they want it every week, I'm like, "No." {chuckles} Because then with our ratios we're not providing that quality programming to everybody else that doesn't attend.*

5.2.3 Shifting Practice Amidst Resistance to Change Summary

To sum up, the theme Shifting Practice Amidst Resistance to Change revealed how

participants noticed that not all residents with dementia were receiving therapeutic value

from traditional large group programs in LTC, and that smaller group or one-on-one MMD

activities were more appropriate for their unique needs and abilities. Although they saw

positive results from residents engaging in MMD activities, participants encountered

difficulties with transitioning to smaller group or one-on-one activities since other staff,

including recreation staff, and family members were used to residents being together in a large group format. Transitioning from traditional programming for residents with dementia to MMD activities was commonly achieved by beginning with a few residents and then expanding to include more residents for whom the quality activities would be most beneficial.

5.3 Educating and Understanding

The theme Educating and Understanding is about how staff and family members were more likely to support the use of MMD when they were educated on its purpose, methods and potential benefits. Education was also useful for participants who were sceptical about MMD as they initially did not understand its value or thought it was a childish or an inappropriate approach for older persons with dementia. The main ways that LTC staff were educated on using MMD were off-site at a MMD workshop, and also at the LTC home through in-services and consultants. Participants reported that families were informed about MMD at the LTC home through one-on-one or group educational sessions. Subthemes to be discussed include: Addressing Negative Attitudes through Increased Understanding; Highlighting the Usefulness of MMD for Staff; Experiencing MMD Training First-Hand; Bringing MMD Education to the LTC Home; and Educating Families.

5.3.1 Addressing Negative Attitudes through Increased Understanding

Participants found that negative or indifferent attitudes toward MMD were one of

the main challenges they encountered when trying to implement it at the LTC home they

worked at. Participants mentioned how providing education and information on MMD

helped staff and family members understand how it works and why they were using it with

residents. A recreation manager said she countered negative attitudes by providing

information on the benefits of MMD:

> *R7: ... continued information to staff and because, just to help them understand*
> *that this is the reason why we're doing this particular, like we did the um, we had*
> *sponges and they were different colours and so we were just having them decide,*
> *you know, where to put them and with the samples at the top. And staff said,*
> *"What are you doing? Like, that doesn't make any sense." Once again we had to*
> *explain to them that, "This isn't about the object itself, this is about that cognition*
> *of being able to identify the colour." And so once you got through, "Oh, oh! Well*
> *that makes sense now." So it was um, lots of different, and then the tactile things*
> *with the macaroni, and it's like, "Oh, what are you doing? They're going to eat*
> *that and choke." "No, we're staying with them. This isn't a program you drop off*
> *and walk away from, this is a program you do with them." So those kinds of things*
> *are, and family responses are to that too, you kind of have to, I guess it's all about*
> *teaching to make sure that people understand what you're doing.*

Participants also realized that some staff were used to doing things for residents rather than

giving them the opportunity to do it themselves. This difference in approach seemed to be

a matter of how they were trained:

> *R4: ... some of the things that we've encountered is just the knowledge base of the*
> *staff. Um, just, you know, that we focus on different areas and so some people don't*
> *understand when we're trying to allow them to be successful and trying to focus on*
> *the positive, we've hit some resistance with some of the staff that they don't*
> *understand why we just don't do it for them. {chuckles}*

Likewise, another participant (R7) found that other staff members did not understand how

the process and engagement in a Montessori activity was more beneficial for residents than

the activity's outcome. She also noted how staff who were not familiar with the theory and

methods behind MMD thought it was inappropriate for residents with dementia:

> R7: ... when I brought home all of the um resource materials from the course I sat down with my staff and we went through everything and really emphasized the process that it wasn't, or the finished product, it was the process of getting there. I brought out all of the sample items that are in the bag and went through each one as to how it would benefit or how they would explain it to other staff if they said, well, you know, "Why are you scooping golf balls into a muffin tin?" So we rationalized as Gail had taught us that, "OK, that motion will maintain dexterity so that they can continue to feed themselves." So that makes sense to a nurse, to a PSW, so because um there's always that ah thought, "Well, this is childish or this is not appropriate." Or that type of thing. So my staff kind of, we all needed to make sure that we were able to explain why we were doing this and that was how we first started.

Some participants commented on how they were sceptical about MMD when they

first heard about it because they associated Montessori activities with children and,

therefore, thought they were not suitable for residents. One participant remarked how she

had to be convinced during the MMD workshop that it was not infantilizing to use

Montessori approaches with residents and so she understood how others could interpret it

that way:

> R11: ... when I first heard of Montessori I just thought it was so juvenile, and, you know, something that I was trained 13 years ago is to never make it childlike, never to make anything so easy, never, although it was the same kind of theories that you never have failure, you never have this, you know? The Montessori when she brought it into me, ah the other manager, it seemed very juvenile, and then when I went to take the course I found out how it still appeared that way until the end of two days so you can really.. {chuckles} I think when you learn it, I think is when you bring it back here and put it into practice, and find out that it appears to be juvenile to people who are on-looking, but once you do it and implement it, it's not juvenile.
> I: OK. So it wasn't until you took the full two-day course with Gail that you got some more insight into how it works?
> R11: That's true. And we brought our concerns to her, and she had to convince us that it wasn't. {chuckles} Which took a little bit of, you know.

A consultant also was concerned that MMD was not appropriate for residents with

dementia until she learned about its theory and application for use with certain individuals:

> C3: It's a little, I have to say, was apprehensive when I went in there, what I had
> seen implemented did not look, I'm gonna say age appropriate, and please take this
> with a grain of salt. So I wanted to get my own read on it and I think people have
> interpreted some of the Methods incorrectly for particular residents. It gives them
> an appropriate activity for a certain resident. There is theory behind which activity
> you pick for which resident and … Without me having that training I wouldn't
> know that.

One recreation manager expressed her initial reservations with MMD being just another

short-lived trend in LTC until she took the workshop and realized its potential for

residents:

> R12: I mean, even myself, and this is my field, therapeutic recreation, I'm all over
> it and I'm always looking for new ways, and I was like, "What's this? What's this
> hokey thing, this Montessori thing?" {both chuckle} And you know, "Oh, this will
> pass. It's just a trend." And then I went and thank God I did! And I, you know, I'm
> ashamed at what I thought initially because it is honestly, you can use it, it's the
> future of TR [therapeutic recreation], in my opinion. And whether you call it
> Montessori or not, it's the philosophies, the techniques, and how you apply it, I
> think it's, you just have to know these things with who we're dealing with.

5.3.2 Highlighting the Usefulness of MMD for Staff

Another way that educating staff increased their understanding of MMD, and

therefore support of it, was by informing them about how MMD is useful for them and

could save time in their daily work with residents. One participant explained how it was

useful for staff on a daily basis rather than just at one point in time:

> R4: I think it's focusing on what the resident outcomes are for them … kind of
> going over the, "If you allow the residents to do this and it helps you in your day-
> to-day, it's not just at that moment."

Another participant found that educating staff on the theory and concepts behind MMD and how they could use it helped put it into practice because then it became a tool for staff and meaningful activity for residents:

> R5: ... housekeeping has been wonderful at assisting, and because it's like the different ideas that I've had, um some of which helps them out as well. Right? Um, and they see the realistic value of it which is really, I was really impressed at that and really surprised at the housekeeping staff because I was explaining to them that like the biggest memory that sticks in people is that functional memory, the functional cognitive skills that we've all had and we've done since we were young, and often they revert back to like the cleaning, the doing the dishes, the folding the clothes, the things that we've done over and over and over again, um that have stuck with us. So I think they really understood that concept quite well that in trying to give people roles. But just explaining the concept has been the biggest thing to overcome the barriers of staff, um still working on some, {chuckles} but it is getting better.

Participants also reported that staff were so busy that they thought any change to the way they work was unnecessary and would take too much time. But MMD actually provided a way to communicate with and engage residents so that staff did not have to constantly address repetitive questions or other behaviours. One consultant (C3) described how she explains the usefulness of MMD to staff and how it could save them time as a way of counteracting negative attitudes. She noted that understanding the theory behind MMD is important:

> C3: ... well, you can either spend the time responding to those behaviours OR you can implement the little two second activity and let them work on it for half an hour and you go do your.. Where you want to spend your time, again they need that theory and the training and repetitive reminders as to it really isn't time consuming, where do you want to spend YOUR time.
> I: Alright. And what would you say are some of the factors or things that make Montessori Methods for Dementia easier to implement?
> C3: The buy-in that it will reduce the frequency of those behaviours, then in turn making it easier for staff to complete their necessary tasks, be it PSWs with personal care rather than having to break up residents that are having some aggression episodes, they can go and do their bedside care while Mrs. Smith is

doing her sorting. And when you really get them to understand that core principle of it, they buy into it.

Another consultant (C5) also found that staff were more likely to use MMD if it eased their workload. She acknowledged that staff needed to be educated on MMD in order to realize that it is a useful approach which could save them time:

> *I: I know you were touching on the next question a bit from some of your previous answers, but how have you seen it enhance the work life of the different staff there?*
> *C5: They've gotta trust it works and they've gotta trust the person who's actually kind of prescribing it and they've gotta … understand the background theory is important … But, ya, it has because most of the people I'm trying to change their routines and really with the PSWs, right? And for me to give them one more thing to do is how they perceive it, but if they work with me long enough they'll see that it's an actual reduction in their work but it's initially difficult to get their buy-in.*

5.3.3 Experiencing MMD Training First-Hand

Educating staff through MMD training first-hand refers to staff experiencing the two-day MMD workshop so that they could learn its theory and methods in-depth while having a chance to practice it and receive feedback. One consultant (C5) commented on how the MMD workshop was useful because any LTC staff member can take the training: *"I really like the way that the whole workshop is bottom-up, it's that you can be trained as a PSW, a rec aide, a caregiver, I really like that this is not top-down, there's not a lot of hierarchy in it."* Other participants noted how it became mandatory in some LTC homes for recreation staff to be trained in MMD as a requirement for working there. A consultant (C1) remarked how this is the case at one home she regularly worked at: *"Some have been certified already and they would like to get a lot of them certified and anybody that gets hired there for activities has to be um, has to have the Montessori workshop behind them."* Likewise, a recreation manager (R12) explained how she started putting MMD into

practice in her home: *"… first by ensuring that all my staff who were going to be the front line producers and such of the programs, we made sure that they had attended the workshop."* Participants also found that it was useful for staff to attend the MMD workshop as they could then learn about it and experience it directly rather than receive information second-hand. One recreation manager explained:

> *R11: … it really helped when I sent them for the course for two days … because you can give them the theories and what's going on, but when they hear it they seem to adopt it a little better. It helped for them to take it for two days too.*

Another recreation manager corroborated this point as she found that her staff benefitted more from attending and experiencing the workshop than by having the MMD theories and concepts explained to them:

> *I: … and was there anything else that helped make it easier to implement there?*
> *R12: Hmm, {pause} by having all my staff go instead of one staff going or myself and coming back and trying to sell it so to speak, right? Cuz it, at that time it was a brand new concept so I could go and I could talk til I'm blue in the face but it isn't until, I find even now, like I have a new staff right now and we're waiting for when she can go to the next training, and she's kind of like, "Ya, OK, whatever." And we're all so passionate about it, but I know that once she actually physically goes to it, she's gonna be like, "Oh my gosh. Wow!" {both chuckle} I think it's important for everybody, you know, in recreation anyways. You can't have one person sort of bring it back and try and sell it, I think everyone needs to be involved in the workshop to really appreciate it.*

5.3.4 Bringing MMD Education to the LTC Home

Not only were staff able to be trained about MMD and its theories and methods by experiencing the MMD workshop, MMD education could be brought into the LTC home to educate staff who could not afford and/or did not have time to attend the two-day workshop. The two main ways of doing this were educating staff via in-services and educating staff via consultants.

5.3.4a Educating staff via in-services

Aside from taking the MMD workshop, staff could also be educated on it through in-services at the LTC home they work at since it is not always possible for staff to attend the two-day workshop. In-services are typically done within the home either during a lunch and learn session or at another time. One participant described what she did to facilitate an in-service for her staff and what was discussed:

> R6: So we actually had an education session for the recreation staff and I had put together quite a few different activities that could be done, um that I had learnt through the course, and just sat down for an afternoon and kind of went over some of those activities and some of the Methods that we could use, and brainstormed on some ideas that we could start implementing in our Montessori program.

Participants also noted how MMD in-service education was important not just for recreation staff but for all staff in the LTC home so they could be educated on it as well. One recreation manager found that it was useful for all staff members to be aware of what MMD is and that it was a new program being used by recreation staff:

> I: … and what type of support did you receive from fellow staff members when implementing the Methods there?
> R4: Just their open-mindedness to the fact that it was something new that we were trying and that um their understanding that it wasn't gonna work for everyone all of the time but, and then allowing their staff to attend some of our in-services so increasing everyone's knowledge, not just the recreation staff.

Another participant thought that hosting in-services for non-recreation staff could also be a beneficial way of changing the negative attitudes of some staff members:

> I: … and how did you address the challenges with dealing with some of the other staff who are outside of the recreation department?
> R6: By doing some in-services with them as well on, you know, the importance of Montessori and just trying to educate them a little bit more on the Methods and how they could use it. Um, like I said, it's kind of a long road with that, with them but hopefully one day we'll bring them on board as well.

Likewise, another participant recounted what information she provided to staff during a

MMD in-service and that it was inclusive for staff from all disciplines:

> *R8: … give them the background of Montessori, how it came about, why it's*
> *effective, why we should be using it in all areas of care, not just recreation, but in*
> *terms of nursing care or housekeeping, how we approach the residents, that kind of*
> *thing. Just an overall, general educational in-services session for them.*

5.3.4b Educating staff via consultants

Another way for staff in LTC to be educated on MMD within the home is through

consultants who can provide information on its purpose and techniques to individual staff

members or a group of them. Consultants are typically requested by a member of the

home's management team to come in and assist with a particular issue or to provide an in-

service on a certain topic. One consultant (C2) explained her role: *"is to increase capacity*

of the staff in working with people with dementia. So therefore, I do education and case

consultations." This was similarly described by another consultant:

> *C1: I do consultations on various residents that are in the long-term care home and*
> *sometimes I'll suggest Montessori activities, um even if they're having trouble with*
> *residents going into the tub or whatever distraction with doll therapy or the various*
> *things to do to distract the residents if they're upset.*

Another consultant explained her process for educating nursing staff on MMD since some

may need more assistance and support:

> *C3: With adults you have to visually demonstrate, then support them while they try,*
> *and then let them go and try it themselves, and be there for support if they need it.*
> *That's kind of my three steps to training. Just doing a lecture will not work with our*
> *health care staff. Many still have literary problems, for some English is a second*
> *language, so that demonstration type education breaks through those barriers.*

One consultant who is a health care professional explained why she is called to come into

LTC homes and what she does with staff and residents using MMD principles:

C5: Most of my referrals are related to, you know, toileting, transferring, continence management, ambulation, things people, they want me to restrain somebody in a wheelchair, and um usually that's not something I choose so you have to look at the alternatives and sometimes that's as simple as using a visual cue like, "Please don't stand up on your own." Things like that. So it just takes a lot of training and teaching them that there's alternatives to locking somebody in a wheelchair... by putting the cues back in the environment. So those things are the things they refer to me and then what I use is some of the Montessori principles along with the restorative principles of, you know, skills from a task breakdown perspective and that's where I find it's very successful.

Consultants also remarked that even though they provided in-service training to

staff at LTC homes, they still encouraged them to take the two-day MMD workshop if

possible. Regarding training staff on MMD, according to one consultant (C2) she: *"would*

be presenting and introducing them to the principles and encouraging them to participate,

take the full two-day training." Likewise, another consultant explained what she would do

to teach staff in LTC homes on MMD:

C4: And then also, if I do develop a short um introduction for the Activity Directors I'll probably go more through the theory as well. Like if I do a short course I would call it more of an introduction and still encourage them to go to the [MMD] program.
I: OK, to the full two-day workshop?
C4: Ya. Like I totally understand some nursing homes can't afford to send their whole department, so a little bit is better than nothing but I would still really encourage them to do that.

5.3.5 Educating Families

Similar to the ways that staff are educated on MMD it is also important to educate

families about how they might use the techniques in their care roles. Families can be

taught about MMD through in-services and other educational sessions in a group or one-

on-one format at the LTC home. Participants described how families needed information

on dementia so that they could understand what their relatives are going through and how

they could help. One consultant used her MMD training to educate families while also

giving them roles and routines so that they could feel comfortable when visiting their

relatives in LTC:

> C5: ... they really need education still on dementia and Alzheimer's disease, like you know it's a buzz word in our community, but they still, when it's your loved one, they still don't understand why they don't recognize them, right? Like there's a huge disconnect of what they know medically and what they feel intuitively and um so when, part of that role is educating them and when they ask, you know, "Why is my mom's legs contracting at this stage of the disease?" And things like that, there's an opportunity to share your expertise and clinical background as far as the diagnosis, but then giving them a role too. What I like about these principles is um it's not just principles we can use with the client but also with the caregiver, providing them with roles and routines.

Another consultant also found that educating families on MMD helped them feel more at

ease when visiting their relatives and that there was a variety of opportunities to educate

them:

> C3: We do care conferences on admission, annually and then as necessary if there's an issue with the resident ... there is a little bit of education and theory to explain to them, but once you do that it seems to ease them a little bit.

Other participants shared their ideas for educating families so that they could

become familiar with MMD and how they could use it. According to one participant

(R11): *"I will be meeting with the family council and then I'll meet individually with family*

members and have little kits ready. Show them what they can do and show them why it

works." A consultant (C1) held: *"an in-service to show them how to do activities,*

meaningful activities with their loved one", while a recreation manager (R8) did the same:

"definitely educational sessions for the families, kind of getting a whole home approach to

Montessori."

5.3.6 Educating and Understanding Summary

In review, the theme Educating and Understanding provided insight into how staff and family members were more likely to support and use MMD in LTC homes when they were educated on its purpose and techniques. Education helped to change negative attitudes about MMD as some staff and family members initially did not understand why recreation staff were using it or how it could be useful for them and for residents. Attending the two-day MMD workshop off-site was one way that staff could learn about it, while in-services and receiving education through consultants at the LTC home were also useful. As well, there were different ways families could be educated on MMD such as through in-services, information sessions, and on a one-one-one basis.

5.4 Seeing Results is Believing

The theme Seeing Results is Believing reveals how staff and family members were more willing to accept and use MMD when they saw the beneficial results of it for themselves. The belief that MMD works made it easier for recreation staff to implement and other staff and family members to use. Seeing Results is Believing pertains to how seeing results first hand changed negative or indifferent attitudes toward MMD. Positive changes seen in residents included increased engagement in daily activities and decreased behaviours. Subthemes to be discussed consist of: Seeing Positive Results for Residents; Seeing MMD Assist with Responsive Behaviours; and Families Noticing Positive Changes.

5.4.1 Seeing Positive Results for Residents

Participants reported that when staff or family members saw the beneficial effects that MMD had on residents they were more likely to have a positive attitude toward it. Seeing results also made staff more likely to use MMD themselves. One participant (R10) said that: *"seeing successes, seeing quick success to get the rest of staff on board"* made it easier to implement MMD in the LTC home she worked in. Several participants remarked that "seeing is believing" was a very effective way to change negative attitudes. This was what one consultant reported:

> *C1: I think it's more, you know, seeing is believing, and if they're there and seeing it work and seeing the residents get engaged and smiling and taking part in an activity, especially residents when they don't think that they're capable really of doing much of anything, and then I think it's a bit of a shocker when they hear a resident being the first to call out the answer to something when they thought all they could do was repeat the same sentence or phrase over and over again and actually to see that those memories are there, you know, we just have to know how to get them to surface.*

Later in the interview in response to some questions about what made MMD easier to implement in the LTC homes she worked in she also commented:

> *C1: I think just when people see the success with it and that the residents are engaged and they do enjoy doing these activities and want to be, have a role or be helpful that um I think that is what gets the other people on board is just to see the success with their own eyes.*
> *I: And as you were saying, it seems to be something more that it's seeing is believing in order for people to find that it works?*
> *C1: I think so, ya because the naysayers if they see it work then, you know, they don't really have anything to fall back on.*

Similarly, a recreation manager described how having staff or families see the positive results of MMD enabled them to believe that it works:

> *R7: The reading program I would have to say is the biggest um, win that we've had not only for the resident themselves but to actually promote our department, like*

activation with nursing staff and families and it's like, "Ah, she reads! Oh my!"
You know? And it's just such a good, positive feeling. So it really is truly amazing
to listen to someone who may not have put two words together in such a long time
and then be able to actually concentrate and read those words.

Another recreation manager described how staff were more willing to believe that MMD

works by seeing it themselves rather than hearing about it from another person. In the

following quote she recalled how showing staff that they were already intuitively using

MMD techniques with residents was more effective than explaining it to them:

> *R11: … some of them already have it and once you point it out they don't even*
> *know they have it, especially housekeeping. They're already, you know, allowing*
> *residents to clean rails and things that they've engaged in and didn't even know*
> *that it would be, you know, making a purpose and a reason for these people for*
> *being here. So once I've been pointing it out more and on the floor more showing*
> *the nurses, telling everybody, nobody listens, but going out there and showing I*
> *think is making a difference.*

5.4.2 Seeing MMD Assist with Responsive Behaviours

Aside from seeing the positive results that MMD activities had on residents, staff

and family members were also more likely to accept MMD as a beneficial technique and

way of life for residents when they saw how it assisted them with responsive behaviours.

In the following quote a consultant explained how evening staff had to see that MMD

works in order to be convinced that it could help reduce responsive behaviours:

> *C3: I think the managers have to come in on the evenings and help work with the*
> *evening shift staff to show them that it does help them in the long run, "If you get*
> *Mr. Smith to do his little sorting of mail envelopes cuz he was a mailman, then you*
> *can go off for half an hour and go do bedside care with Mrs. Jones." If they see it,*
> *you know, {chuckles} they will come, I don't know what else to say. Just show them*
> *that it works.*

A recreation manager had a similar experience when using MMD:

> *R11: … as I told them in the morning report today cuz it was some kind of problem*
> *with one of the residents, and I just know if I go over there and do it myself cuz I*

can see that there's an answer to the solution. But I know that they have to visually see me doing it, before they accept it themselves. {chuckles}
I: OK, so they have to see you do it before they'll believe that it really works?
R11: Yep.

Participants also reported instances of staff and family members changing their

attitudes toward MMD as a result of seeing how it helped comfort residents. A consultant

explained the reluctance that some staff felt when she encouraged them to use a lifelike

doll as a MMD technique to calm a resident during bathing:

> *C1: ... there's always people that are kind of set in their ways and the naysayers ... in particular the doll therapy where they thought it was infantilizing somebody to give them a doll, but again when they see how they react to the doll and that it brings them joy that it, you know, they're more likely to come on board with it. And I actually had a woman that was in long-term care that was intellectually challenged too and um she was very, didn't want a bath whatsoever, was really fighting the girls over being bathed and we found that if she could bring her baby doll in and bath the doll while she was in the tub, she was so busy doing that that it was no longer a challenge to bathe her, so. Mhm, so quite a success with the dolls.*

Another consultant found that nursing staff were more likely to accept and use MMD

techniques after they saw how it eased responsive behaviours:

> *C5: I call it my "wins column". Trying to win the staff over by really um, fixing the behaviour that's become a problem on the unit, and so I try to really focus on what will be successful immediately for the family and the staff, and then once I gain credibility I can then move on to the other areas of programming. So usually I pick things like, you know, when the clients are asking, "Where's my medication? Where's my medication?" or, "I want to go to the washroom. I want to go to the washroom." I try to focus on fixing, assisting with those programming ideas using the Montessori Methods because nurses really respond well when I've reduced repetitive questioning or asking to go to the washroom, so those are some of the hot spots I usually choose first before I go and say, "Let's set up a reading group. Or let's set up a memory sort." Or something like that.*

Likewise, a recreation manager explained how MMD was easier to put into practice when

staff saw the positive effect it had on the behaviours of residents:

I: What were some of the factors or things that helped make Montessori Methods easier to implement? It sounds like from what you said before that- {R11 interjects}
R11: It's more visual effect, you know, when they see it, they believe it ... some of the behaviours had stopped in certain residents that they are doing Montessori with. It's not a 180 degree change but it is slightly.

5.4.3 Families Noticing Positive Changes

Participants also reported instances where family members noticed positive

changes in their relatives after MMD activities started to be used in the LTC home.

Regarding the changes that family members noticed in the dementia care home area, a

recreation manager recounted:

> *R7: I think there's definitely been a reduction in responsive behaviours for those people that we have put specific programs in place with. Um, most definitely the um, families I feel are more secure in what we can offer their loved one because, again, when they come in, not all the time, but sometimes when they come in their loved one is engaged in an activity where, you know, maybe six months ago that person would just be exit seeking or wandering, and I think they appreciate that ... someone who hasn't been able to focus on anything and just wants to wander, could even focus for 10 minutes. I think that's been a huge, so which again, you know, if they focus for 10 minutes then sometimes we can get them to stay at the lunch table longer.*

The same participant also added:

> *R7: ... we certainly get feedback verbally but we have had family members actually call the Director of Care and, you know, say what a difference the area is because there's purposeful programming that's going on in there, that the tone of the environment has just completely changed. So that's really positive.*
> *I: OK, and the tone of the environment has changed since using the Montessori Methods?*
> *R7: Most definitely, most definitely.*

When asked about families' responses since MMD was introduced in the home another

recreation manager similarly commented:

> *R9: Family members notice that their loved one is more engaged and more content. And they're surprised maybe at what they can do.*

I: Do you have any examples of how they've been surprised by what the person can do?
R9: Um, just about, they'll say, you know, "I can't believe how much they talk now." Or we'll talk about the activity that we did and what the resident said during the activity, and they said, "Oh, I'm surprised that they were able to remember that, or that they would know that." Things like that.

5.4.4 Seeing Results is Believing Summary

To sum up, Seeing Results is Believing demonstrated how witnessing positive results changed the negative or indifferent attitudes that some people had toward MMD. Staff and family members who were sceptical about MMD changed their view when they saw residents become more engaged in daily life and how it assisted them when responding to behaviours by involving residents in meaningful activities. Basically, seeing the effects of MMD tended to have a beneficial impact on "naysayers" who questioned MMD or the abilities of residents with dementia.

5.5 Being Supported

The theme Being Supported denotes how participants found and enlisted the support from various sources in order to help implement MMD. Support was found both within the LTC home from staff, colleagues, management and families as well as externally through consultants. Subthemes to be discussed include: Finding Support and Learning from Staff and Colleagues; Being Supported from the Top; Drawing on Consultant Support and Resources; and Enlisting Family Support.

5.5.1 Finding Support and Learning from Staff and Colleagues

Participants noted that they readily found support with implementing MMD from staff and colleagues within the recreation department as well as from some staff outside of it. Within the recreation department, staff were enthusiastic to learn more about MMD and help their colleagues or supervisor put it into practice. According to a recreation manager whose staff were somewhat familiar with MMD, the support she received from them made it easier to implement:

> I: ... and what support did you receive from staff members when trying to put the Methods into practice there?
> R6: Really good support. Like I said, they had already been doing it, just not really doing it well and I think they were really receptive because they wanted to learn more as well and ah figure out what they were doing, you know, or what they could be doing better to make the program better.

This was similarly reported by another recreation manager (R9) regarding her staff. She said: "*they're very supportive ... eager to implement the program and work with each other to make sure it was implemented.*" Some recreation managers stated that they had regular meetings with other recreation managers in their company where discussions regarding MMD were one of the topics:

> R11: Well, I've had a little bit of follow-up with our regional managers. So we just had a meeting on Wednesday in [city name] so we all, again, talked about Montessori, what's working, what's not, and what we can do to make changes.
> I: OK, so it's kind of like a team meeting just to find out what other homes are doing or..?
> R11: Yes, we have these um, on a quarterly basis anyways. So Montessori now is thrown in there for part of our agenda. And it's mostly people sharing during that time success stories. "Couldn't get her to do anything and she was folding clothes." And you know? {chuckles} Those stories, they're nice.

Aside from receiving support from staff within the recreation department, participants also reported finding support from some departments in the home and

resistance from others. Housekeeping and dietary staff were said to be most supportive

while staff from other departments could be challenging. According to a recreation

manager:

> *R3: … so I already discussed the nursing staff not being supportive um, I've had a lot of support from the dietary department just in terms of being flexible with their timing or with their set up for some of the things that we've done they've been really great. Um, the laundry department has been really difficult in terms of … consistency, especially at the beginning they [aprons] would come up unfolded one day and then the next day they would come up folded and then for a week after that they would come up folded and, you know, it was really hard to get them to not fold them so that we could do it. But from my staff it's been great and from some people it's been great but we have had quite a bit of resistance from people who aren't from our department.*

This was corroborated by another participant who had a similar experience:

> *I: I know you were saying that housekeeping was very supportive, so was there any other people who were also- {R5 interjects}*
> *R5: Ah, actually there was one other girl in my department who is … thinking about taking the workshop because of how, what great ideas I've received and when explaining the concept of it to her. Um, but ya the, I've got support from dietary. Most of the people have been very supportive, there's just been, there's always those couple those few that really stand out and make things difficult but other than that … I would say that housekeeping is the most.*

A recreation manager also noted that she received the most support from staff and

management who were not in a medical discipline:

> *R12: … when we meet every morning as a management team to discuss sort of what's been going on in the home in the last 24 hours and we touch on some need, you know, around working on motor skills with someone or anything like that, that cues me an opportunity to throw in one of these ideas, I do it, cuz everyone's there and they've all heard me. And it's usually the non-medicinal folks, like our social worker or our business manager even, who are more open to it and say, "Hey, ya!" So I have that support I need for them to kind of have to say, "OK, give it a try."*

5.5.2 Being Supported from the Top

Being supported from the upper levels of staff within the LTC home – from management – was another common way that helped participants put MMD into practice. Managers would request their staff to be cooperative, would provide financial support, and would also provide encouragement to the person or group trying to implement MMD for the benefit of residents. Regarding finding support from management to ensure that staff would be cooperative, one of the consultants noted:

> C5: ... making sure from top-down in the long-term care facility that there's administrative buy-in that the management staff, the director of care buys into this too, because ... it's a bottom-up training so it's at the field level, anybody can use it, um we just need the top-down to support it.

Similarly, when asked about how she would like to overcome the lack of support and attitudinal barriers from staff in other departments, a recreation manager (R3) also mentioned that top-down support would be useful: *"it's something that I can discuss with my director and maybe she can kind of push from the top to get some buy-in from the directors so that they can push it down to their staff."* Another recreation manager (R11) got her staff to support MMD by simply adding it to the activity calendar that they work from: *"because I'm the manager I can just put it on the calendar, and once I did teach my staff somewhat of the theories um, they got on board right away because it was on the calendar."* Likewise, a consultant found that supportive management helped put MMD into practice since there are so many other competing priorities in LTC homes:

> C2: ... any given day there could be so many emergencies and so many crisis situations because most of them have a lot of mental health people now and they don't have resources, they don't have on-going psychiatry help with people with younger age and all those kinds of things. So there's a lot of crisis situations going on and everything else, you know, this Montessori for example, goes under unless

> *there is a manager who is very strong and who can very determinedly take the agenda forward, and that I see in one home happening because of the manager.*

Other participants also noted that management were supportive of their efforts to

implement MMD as a way to meet the needs of residents due to the increasing mix of

residents with dementia and younger persons with mental health issues in LTC. A

recreation manager noted that it was a regional manager who first informed her about

MMD as a new technique to use with residents:

> *I: ... so what was it that drew you to the Montessori Methods for Dementia workshop?*
> *R12: Um, we recognized the increased need for programming tools and non-conventional programming tools to help meet the increasing dementia demands of our residents. Like it used to be one little home area in our home and then it started to spread throughout the home, and we just needed new directions and new concepts to drive our programming for the majority of the residents in our home. And it was actually one of our regional leaders in our company that told us about this Montessori Methods for Dementia workshop.*

Similarly, another participant received support from management to use MMD as a way to

accommodate the various needs of residents:

> *R5: My supervisors and managers have been very supporting. Um, I've had the support of them going into this course, in taking the workshop, and then ... in implementing the ideas in my specific unit ... So the management has been wonderful and supporting the idea and the concept because they want to see the change because ... we're now starting to see the mix of people coming in with mental health issues in addition to Alzheimer's as well as people coming in with disabilities in addition to Alzheimer's, so it's really, it's broadening the need for change in the way that we approach it.*

Other types of support included general encouragement and advice for staff when

they needed a different perspective or idea with an issue they were having. A consultant

spoke of how she would turn to her supervisors for advice:

> *C3: ... sometimes it's just an ear when I want to vent and say, "What do you think about this?" And sometimes it's validation, like they've been certified and can go,*

> *"No let's go back to the theory and practice." You know, to get me back on the right track. Um, sometimes it's just thinking outside the box and you need somebody to challenge you to do that … Sometimes you just have to bounce ideas off of each other, and my colleagues and my supervisors are good at that.*

Financial support from management was also identified by participants as key when implementing MMD. Financial assistance was required in order to pay for any needed materials and to also send staff for training. One consultant described the types of financial support she received from her managers:

> *C1: … when I came back after taking the workshop I had asked about would it be a possibility for me to be certified, um that maybe I could teach in this area either the nursing homes or in the [city name] area at [health care company name] and they thought it would be an excellent idea and so they offered that yes if I decided to be certified that they would pay my way to do that. So they're right on board with it.*
> *I: OK and then was there any other type of assistance that you received from your supervisor or manager there?*
> *C1: Just that if I had wanted to purchase any items for the various activities that I could put the costs through them.*

Another participant explained how she received support from both her local and upper-level managers to implement MMD and purchase materials:

> *R4: … it's been very positive here at our home as well as um in our whole corporation they believe in what we're trying to accomplish and have given us um, financial backing in order to purchase additional materials for all of our kits.*

5.5.3 Drawing on Consultant Support and Resources

Consultants supported LTC staff with implementing MMD by sharing their ideas, expertise and materials, and they also fostered relationships between different disciplines in the home as well as between staff and management. A recreation assistant (P6) first heard about and became interested in MMD through a consultant during a meeting at the LTC home she worked in. She explained:

> *P6: I'm part of the responsive behaviour committee at the long-term care centre where I work and we have the psychogeriatric specialist that comes in [and] asked me directly if we're using the Montessori approach. And I looked at her and said, "No, actually no we're not using the Montessori approach right now." I had no clue what she meant. {chuckles} ... So it was at our committee meeting that I found out about it and then became very interested in it.*

As part of their role in supporting and educating staff, consultants tended to have various

MMD materials that they showed staff to give them ideas of what they could purchase or

make based on the needs of their residents. One consultant explained:

> *C2: The reason I bought all the materials is even though I'm not going to be individually working with them but I could take them, show them to generate interest ... because if I show them rather than just talk about them then maybe there is more interest and see, "Yes, this can work with this person in my group." Or something like that.*

Another consultant also used her expertise and materials as a resource to share with staff to

help them put MMD into practice:

> *C3: I did purchase one of those kits while I was there at the two-day workshop. Again, to have some base for me to do training to my program staff and aides and whoever, and just if I'm in a home to take something and try it with a resident to give me ideas of maybe some other activities that we could have or look at what they've got in the home and go, "Well, that's a Montessori activity! Did you realize that's what you were doing?"*

Some consultants used their MMD materials to create activities for residents which saved

staff the time and cost of making it themselves. One participant described what she did

and why:

> *C4: ... what I do is I go in and I basically create activities and I have them in a box sort of, and then they can keep them right in their room. My goal then is that the nursing staff will use it rather than seeing it just as an activity department program, because the problems are often when the activity staff is not there, and having worked in activities, I know that that happens. ... The staff who have used it really like it, and the activity staff like it because, and I know this is the case from working in activities myself, a lot of times they don't have as much time to develop an individual program. A lot of times activities departments will ... operate it [MMD] as a program like an hour a week, um and this is a way to have it*

individualized to the actual person ... it's something that I can offer that the activity departments sometimes don't have time to do.

Consultants also used their expertise and relationship with management to encourage them

to purchase certain materials or products that are useful for MMD activities:

C5: ... what I do is write out a wish list for the administration and I give them pictures and I give them the resources from the catalogue, and then say, you know, "If you have money in the budget at the end of the year, these products you'll find very useful." And I explain that, sort of the breakdown of how they're practical and how they give a sense of sensory and tactile feedback to the client if you've got the right product. And you know, 9 times out of the 10 they find that they will support the programs financially as well.

Consultants also worked to liaise between recreation staff, management and other

departments to help implement MMD. One consultant described her role as follows:

C2: I see my role is just supporting the interest with the recreation staff, and ah helping them to take the steps towards using this. Whether they have to present something to the management to get approval or something, I would assist them with that.

Fostering communication between different disciplines, particularly between recreation

and nursing staff, is important as this consultant saw it as a key element in implementing

MMD:

C5: So part of my role is actually to make, just to help the rec staff to gain some more professionalism, some more respect because I think what happens on the dementia units is the nurses are exhausted running off of their feet, and then they see that there's supposed to be a program and the rec program comes and it's only, you know, addressing a few of the behaviours, they don't know enough about the resident, they're not privy to the information the nurses have so it's really a communication failure in the homes.

Overall, consultants served as a general support for staff members wanting to use

MMD or to encourage staff to use Montessori principles and techniques. One consultant

described how she could serve as a facilitator for recreation staff trying to use MMD in the

LTC homes they worked in:

> *C2: ... in a few of my nursing homes now, especially in one nursing home, all recreational staff have taken Montessori training. So when I talk to them I said, "How is it going implementing or bringing some of the material to the practice point?" They said, "Not much." {chuckles} So then I thought, "OK, I could facilitate this group or just be active behind the scenes with this group." So that they can coordinate themselves, bring more Montessori principles, ah use more of those methods in their work.*

A recreation manager (P16) corroborated this as she found that a psychogeriatric resource

consultant helped her put MMD into practice. When asked about which forms of follow-

up assistance regarding MMD were useful, she stated:

> *P16: You know, we just had somebody come in today from [one of] the hospitals, who are nurses that are more of a resource. Um, they're called psychogeriatric consultants?*
> *I: Right, yep.*
> *P16: Yes, so she's right on board about Montessori. So that's great, like when she comes in they don't just talk about medication or putting residents into CAM-H [Centre for Addiction and Mental Health] or those places. They're really on board with Montessori.*

Another consultant explained how she used MMD to support nursing staff in their day-to-

day work with residents which helped to reduce their reluctance to use it themselves:

> *C5: I try to pick the cases that I know will be successful in a short time, so things that the nurses are looking for I try to speak their language to support them in their jobs because they're 24/7 and I'm just one day a week. So once again I speak the things that will speak success to everyone which is usually continence program or dressing program to increase independence on the resident's side there, or if it's the resident with frequent verbal outbursts or things that are just driving people crazy, the repetitive questioning, it's sort of looking at those behaviours and trying to give them strategies or ideas.*

5.5.4 Enlisting Family Support

Families also provided support for implementing MMD in LTC homes in various

ways. They contributed financially by covering material costs, they helped put MMD into

practice by participating in the activities with their relatives, and they gave their personal

support to staff during meetings. Regarding financial support, staff and consultants turned

to families for assistance to pay for MMD materials that the LTC home could not afford.

A consultant described her strategies for enlisting family members to help pay for

materials:

> *C5: I went to resident council, did a little presentation for the benefits because*
> *there was no money and they have a fund there, so you know, I tried that or I will*
> *submit something into the newsletter at the nursing home because families like to*
> *help and they have things and resources available to us too. ... sometimes we have*
> *to ask the families to buy some of the things, say like the weighted dolls, they're*
> *expensive, like they're between 60 and 80 dollars ... Even for the readers and*
> *things I find that we might have them and then things get lost or misplaced or*
> *someone takes it home by mistake and then you have to replenish them all the*
> *time, that's an issue.*

Another consultant also noted that she asked families to pay for MMD activity materials

since the company she worked for and the LTC homes could not always afford to:

> *C4: ... we do run into who pays for it. In this case though, the families have never*
> *had a problem with that because really it's never very expensive, it's usually less*
> *than 20 dollars, and they, the families love the individualized attention, you know.*

Regarding family support to help put MMD into practice, participants noted that

their assistance is useful since staff are not always available or have enough time to spend

with residents. When talking about how to expand MMD in her LTC home with an

extremely low staff-to-resident ratio a recreation manager explained:

> *R12: ... we know that it can work, we know that it does work, and the frustration*
> *lies in time, um our ratios, we have a one to 60 ratio with our recreation staff. So*

> *how can we use this the best that we can based on those ratios? I mean, ideally, it would be to have it on the floors for other staff to do, for families to do, for volunteers to do.*

A consultant (C5) also described how assistance from others, including families, can help put MMD into practice: *"it's difficult for me because I'm in a consultant role, so I'm only there once a week at my facilities and so I'm really dependent on training the staff to do it or the families."* Another consultant (C3) agreed: *"Families can come in and participate in that if they're aware and educated on it as well. Getting family participation is a factor that helps it too."*

Aside from doing MMD activities with residents, families also encouraged staff to put the methods into practice by lending their support and encouragement during care conferences. One participant described how the wishes of families to try MMD techniques with their relatives were respected by other staff:

> *R12: ... when we have multidisciplinary care conference for residents, so we talk about where they are at, and all of that, and you know, a concern or a discussion is brought up and the doctor's talking, and the nurse is talking, and I'll just throw in there, "Hey, why don't we try this?" And they're like, they kind of look at me like "What?" And to be honest, it's usually the family because they aren't medical, and they're like, "I don't know what you guys are talking about, but what she's just said is probably something that's more on my level and I can understand, and is kind of everyday more realistic to me." And then because the family's there and they've gone, "Ya, let's try it!" All of a sudden the medical folks are like, "OK.." {chuckles} So it's kind of using those people as my support in the moment.*

5.5.5 Being Supported Summary

To summarize, the theme Being Supported detailed the various ways that participants sought assistance with putting MMD into practice in LTC homes. Participants found the most support from colleagues in the recreation department in addition to staff from other departments, management, families, and consultants. Support from non-

recreation staff was typically provided by staff who worked in disciplines that were not

medical. Participants needed encouragement and assistance from others as well as their

expertise and financial aid in order to implement MMD.

5.6 (Re-)Connecting People and Passions

(Re-)Connecting People and Passions refers to the ways that MMD enabled people

to meaningfully connect with residents with dementia. MMD also served as a means for

staff to reconnect with the reasons that they chose to work in LTC. Using MMD

techniques and activities, staff felt a renewed sense of purpose and excitement for working

with residents while families appreciated being able to have successful visits with their

relatives. The subthemes to be discussed are: Fostering Meaningful Connections with

Residents; Facilitating Meaningful Family-Resident Connections; and Reconnecting with

Confidence, Passion and Purpose for Working in LTC.

5.6.1 Fostering Meaningful Connections with Residents

Staff found that MMD was a way to connect or re-connect with residents that they

either had trouble communicating with or difficulty finding an activity that they enjoyed or

wanted to participate in. Participants discovered that MMD provided them with a

meaningful way to engage with residents. When asked what she thought about MMD, a

consultant described how it can foster meaningful connections between staff and residents

with dementia:

> *C2: I think they are very useful. Um, what I like about them is how they, how you*
> *connect with people who are um suffering from dementia no matter what stage they*
> *are in by offering them something that they can relate to and that they can connect*
> *with ... When people connect then a meaningful interaction occurs and I've seen*

> *Montessori Methods allows staff to connect with these individuals and make a meaningful interaction, meaningful activity happen, and that I feel is amazing because, you know, otherwise it is so easy to say, "There's nothing I can do for her, nothing I can offer." Kind of thing. So I feel it goes to the basic ah human connecting and connectedness to each other.*

Another consultant reported how a MMD activity enabled staff in LTC and in a hospital to connect with an older man with dementia who was having difficulty transitioning to LTC:

> *C4: The one guy that I worked with, he was having a lot of trouble. He ended up going to the hospital then, like as a temporary place, and then after that he ended up going to the nursing home with the secured unit ... And I think the hospital staff really liked it as well, um and, you know, I think it really helped him sort of keep hold of who he was, like in the place where he still thought he was. And that the staff at both places could really connect to that [ethnic] element that was important to him, that is really important to him at this point.*

Another participant described how by putting pictures and stories on the wall in the dementia care home area where she worked not only gave residents an interesting activity, but it also served as a conversation piece for staff to engage with residents:

> *R5: I've put some information up on the wall, um I've got a 'tool of the month' ... very brief information about the wrench and big bold print, I did the 36 font like it was said in the workshop which is the best to read, and I had all the information up and I've had three gentlemen that are in wheelchairs that'll just wheel up to there, like foot propel, and sit there and stare at this wall and will read it! And I've had comments from other staff as well that have gone up to them saying, "Oh, what are you doing?" and they're like, "Oh, I'm reading about this wrench. And did you know that this and this and this?" And they've read it all off to them and recited it, so it's been effective and it's giving them something to do while they're just essentially wandering through the unit but they're now having a purpose.*

Similarly, a recreation manager also found that MMD served as a way of connecting with residents:

> *I: So what are some of the changes or results that you've seen since using Montessori Methods for Dementia in the long-term care home there?*
> *R12: Um, connecting. Connecting with certain residents that we really haven't known how to connect with before. Ah, and providing them with meaningful activity as opposed to just general fillers in their day ... that's what's been really special.*

Participants also recounted how they were pleasantly surprised to find that MMD helped them connect with nonverbal residents who were still very capable despite what they or other staff assumed. One participant noted how using a Montessori-based activity really piqued the interest of a resident who staff thought was unresponsive:

> R2: I know that she loves animals and she's always been a dog owner … So I got her a dog magazine with picture of dogs in it to look at, that we look at together … staff claim that she sleeps all day and that she's not responsive and she doesn't want to go to programs and so forth and so on. But when I'm with her with the dog album, her eyes are open and she's helping me to turn pages and she's reacting, you know, and you can see that there is something going [on] with her, that she's enjoying this activity.

Another participant described a similar breakthrough she had with a resident who staff had difficulty connecting and communicating with:

> R6: We've had one resident in particular who um, she's nonverbal, and so it's really hard to communicate with her and often times she just sits perfectly still and we put her up to a table with um, we were doing some flower arranging and she just reached out and started doing it and we were kind of all shocked, like we didn't know that she had the capability of doing this. So it's those little things that you notice on a regular basis.

MMD also served as a tool for connecting with residents who spoke English as a second language (ESL) and had reverted back to their native language as their dementia progressed. One participant noted how useful MMD was for connecting with residents with whom they previously did not know how to communicate:

> R12: Even individuals, um, around communication … it's been a fantastic, fantastic tool for ESL residents who have reverted back [to their native language] and there's that language barrier, because you really don't need to talk. And um, just, what else? So then it expanded there, and in terms of residents who are aphasic and stuff like that, so we were able to expand it not only just for dementia but suddenly these other residents who we really didn't know how to reach, it was working for them too.

5.6.2 Facilitating Meaningful Family-Resident Connections

Not only was MMD useful for staff to connect with residents, but family members were also able to use MMD techniques and activities when they visited their relatives. MMD was a tool that families used to connect with their relatives for successful visits as participants reported that visiting could be difficult for families. According to one participant (R11): *"we see the frustration in family members too, they come in and don't know what to do, and don't know how to deal with it, and "Why does mom always behave this way when I'm here?""* A consultant described how using a Montessori-based daily activity planner provided a family with ideas of what to do when visiting their mother who no longer recognized them:

> *C3: I use the example of that journal/diary that I made up for one resident, they took it to the care conference, explained it to the family, the sons, and its usefulness in that he could refer to it whenever he was in … Cuz sometimes families get lost when they come in as to how to have a quality visit with their loved one when "mom doesn't even recognize me". So this gives them a tool also to have that visit in a meaningful manner, "Even if she doesn't know me, I'm just going to participate in this activity with her and be happy with that."*

Sometimes family members were unsure of how to interact with their relatives with dementia but MMD activities gave them a way to connect using activities. This was described by another consultant:

> *C4: … the family members that I have been involved with really appreciate it. Sometimes it gives them a place to connect as well.*
> *I: OK, so just as a way of connecting with the person through the activities or..?*
> *C4: Yes, ya.*

In another instance, a consultant recounted why she advised family members to use the MMD readers as an activity:

C5: ... it's easy for me to say to them, you know, "You need to go get the reading books because your mom can still read." And they're like, "Really?!" {chuckles} And so that's, I like the reading program for that because that's a purposeful activity they can do with them when they visit instead of having them always saying, "Who are you? What's the question?"

Participants also reported how families appreciated having Montessori-based

activities to connect with their relatives who could not communicate verbally. According

to a recreation manager, MMD:

R4: ... allows them to engage in something with their loved one so it's not all focused on them coming to visit and, you know, not being successful because that person's no longer able to verbally communicate. We're showing the families different ways in order to allow them to have a successful visit.

Another recreation manager described how engaging in a creative MMD activity with a

nonverbal woman with dementia enabled her to communicate in writing with her husband:

R7: ... we had a really successful breakthrough with one of our residents. I had a student working with her and they were colouring and drawing, and she took the pencil and she actually wrote to her husband of 61 years, "I love you, [name of husband]." And it was like, you know, "See, this is what can happen." ... and when the husband came in and she gave it to him, I mean you could, the whole place was just, they were in tears because it was just so amazing for her to have that last chance because she's certainly nonverbal and so that's pretty, pretty touching.

After being inspired at the MMD workshop to change the environment where she worked,

one participant created an area at the end of a hallway where residents and families could

spend time together and connect using activities that did not require conversation:

R5: There was the end of an hall that was just empty, and in that end of the hall I've created a little area where I've got a desk and a chair, um some pencils and paper, and on the other side it's basically a little nook area and I've got a couch and a comfortable chair and a little table with photographs books of like different travels. And that seems to have been the best so far and the most used by all the residents, and even family members as well. Like I've seen people actually sitting with their spouse and flipping through the books and just enjoying, even though they don't have that communication for some of them anymore, they're still looking

like they're enjoying themselves like they once did and sitting close ... I've actually had two family members specifically come up and thank me for that little area cuz it gave them something to do with their family members.

5.6.3 Reconnecting with Confidence, Passion and Purpose for Working in LTC

Participants also described how MMD enabled them to reconnect with their passion and purpose for wanting to work in LTC and increased their confidence in their abilities. Some participants were becoming frustrated at how the programs they had in place for residents with dementia were not meeting their needs, which made them feel that they were not doing a good job. Many described how MMD created positive results for residents which in turn made them happy and feel confident. One recreation manager (R4) noted how she and her staff derived: *"satisfaction in allowing the residents to be successful. And looking at the positive resident outcomes."* She went on to explain:

> *R4: ... it has increased our comfort level with working with some of our residents in the middle to later stages of dementia, and also um allowed us an opportunity to program for everyone and not exclude because of their disease process.*

Likewise, another recreation manager noted how MMD:

> *R7: ... definitely has given my staff a boost that they're accomplishing what they want to do, to do a good job with, for the residents ... They were getting frustrated that the programs we were trying to do weren't matching the abilities of the residents, and so that just kind of, this has given them a positive um, they're bringing something positive to the area.*

Other recreation managers also found that using MMD in their LTC home changed the way they created programs for residents and the favourable responses they received:

> *R6: I feel like um, you're not just going in there anymore and just doing a program for the sake of doing a program, you're actually doing something that's meaningful, and you're getting positive responses from residents instead of just a lot of blank stares.*

This was similarly reported by another recreation manager:

R12: ... I know for my staff, like when they, every time they try they have a success with the resident, it's just a such a fantastic feeling for them too, that they are providing more meaningful interventions with the residents as opposed to [regular] programming.

Other participants explained how seeing positive results using MMD with residents reconnected their passion for working with residents with dementia. According to one participant (R3): *"you see improvement in people and um, you see people who maybe aren't always actively engaged, really engaged and that's good because it makes you want to come to work."* Likewise, another participant (R5) commented regarding MMD: *"it's really motivated me to get new ideas, and basically a fresh outlook ... It was new ideas and new concepts, so it basically got me excited about my job again."* One recreation manager described how programming for residents was becoming repetitive before she and her staff took the MMD workshop and that they were excited by the positive results and the creativity it inspired in them:

R12: I've been in the field for 12 years and it gets kind of, it was getting stale, and I know people who've been in it longer than me. It's like everything just gets kind of boring and repetitive, and you really, you start to question yourself as a professional when everybody else is already doing it. And being able to come up with something for each individual that walks through this door as opposed to just running the same [activities] every day with different people showing up, um it kind of, it keeps me excited about what we do. ... when you see the results when you go back and you go through all the different stages with these residents in the Montessori Methods they, it really reminds you of why you continue to advocate for what we provide, because it's always different with each individual. You can't take a sorting buttons program and expect it to just be sorting buttons with everybody, it's going to be different for each individual, and that keeps it exciting. {chuckles}

5.6.4 (Re-)Connecting People and Passions Summary

In review, the theme (Re-)Connecting People and Passions illustrated how participants used MMD as a way to engage with residents who they previously had difficulty connecting with. Participants found that MMD was useful for staff and for families to meaningfully connect or communicate with nonverbal residents or those who did not speak English. It also enabled families to have a quality visit with their relatives with dementia rather than an upsetting visit. Furthermore, staff developed a sense of confidence in using MMD and felt good about the results they were seeing in residents because of their efforts. In this way, MMD reconnected them with their passion for wanting to work in LTC.

5.7 Improving Residents' Quality of Life

The theme Improving Residents' Quality of Life illustrates the various ways that MMD resulted in positive experiences for residents with dementia. Participants recounted how using MMD activities improved residents' quality of life by engaging them in meaningful activities, roles and relationships as well as reducing the boredom and fear that can trigger responsive behaviours. Subthemes to be discussed include: Enabling Residents to Enjoy Life Again; and Reducing Boredom and Meeting Individual Needs.

5.7.1 Enabling Residents to Enjoy Life Again

Participants found that MMD enabled residents to enjoy life in LTC by increasing their involvement in daily activities, roles, and relationships. One participant (R11) expressed why person-centred activities like MMD are so important for LTC residents:

"*we are in a home … I think that's the biggest part with Montessori, you know, is that they're not just here to die, they're actually here to have a quality life.*" Regarding whether MMD enhanced the quality of life of residents, a recreation manager (R6) remarked how it gave their lives purpose and meaning again: "*it's definitely given them some meaning to their life, something to do again, that it's given them purpose. They're not just sitting there, you know, hour after hour with nothing to do.*" Another recreation manager noted that residents felt content both during and after they participated in a MMD activity such as reading:

> *R7: In the moments when they [have] a positive experience, I mean, you can see that it's reflected in their faces. Like when someone is reading, they may not know that they hadn't been reading, but when they're reading it's, you know that it's positive, you know that it's making them feel good. And if they've been involved in a program, the agitation level is lower, or maybe it's not agitation but the frustration level is lower.*
> *I: OK. So it's lower when they're in the program or when they come out of it or..?*
> *R7: Well definitely when they're in the program it's not as, it's certainly not as visible, but even when they're, after the program is finished it's more of a contentment. It's like they've used some energy in a positive way.*

Another recreation manager, who had been tracking the impact of MMD activities, also noticed the beneficial effects that MMD had on residents such as their increased engagement in activities and involvement in daily life:

> *R9: … they come out of their rooms more on their own, walk around the home a little bit more on their own, whereas before they would just keep themselves in their room all day, not speak to anybody. They initiate conversation on their own more. And they have a higher level of engagement during the activity as well.*
> *I: OK, and is that just with the Montessori activities or..?*
> *R9: Yes … they're much more engaged, content, not so apathetic or isolating themselves.*

Likewise, a participant explained how MMD activities gave residents a way to be an active part of the home based on the previous roles they had before moving into LTC:

> *R4: I would say that it has allowed them to increase their self-esteem and self-confidence and also allowed them to feel as if they're able to engage in the community here. Some of the tasks that they have are roles that they have taken on are things that, you know, that they might have done in their previous life and therefore is helping the home and so then they feel like they're accomplishing something.*

Participants also stated how MMD enabled residents to return to their former ways of living by increasing their independence and improving their quality of life. One recreation assistant recounted how using MMD techniques enabled a resident to relearn to feed herself:

> *R2: And with the whole dietary aspects with giving her more empowerment with eating and breaking down the task of eating a meal into more manageable steps ... Her quality of life is definitely better, and her independence is improved and this whole learned helplessness that is come into her by being fed like a child just because [she] moved into long-term care, you know that is eased with the Montessori approach.*

Similarly, a recreation manager found that Montessori-based scooping activities helped residents regain their ability to feed themselves by improving their dexterity:

> *R11: ... scooping really helps with them maintaining their own eating, people who even have lost the ability now doing the scooping and a lot with restorative [care staff] are actually being able to pick up the spoon and feed themselves.*

Aside from eating, MMD techniques were used to ease residents' fears, enabling them to return to their familiar habits and routines. A consultant described how MMD alleviated the worries of one resident by putting a picture of her new doctor in her environment which improved her quality of life:

> *C5: ... one lady who wouldn't sleep all night because she thought it was the wrong doctor prescribing her medications until we showed her a picture of her old doctor and then her new doctor. Because then her anxieties are gone and they're not sedating her at night and we put the cue in the environment to remind her and then within two weeks the behaviour is gone and she's not anxious and she's back to her old self playing bridge, you know. So for sure there's increased quality of life,*

there's freedom, there's less restraints, there's less falls, there's less boredom, so all those things are wonderful.

5.7.2 Reducing Boredom and Meeting Individual Needs

Participants also reported that MMD activities helped to increase residents'

enjoyment of life and, thus, improving the quality of it by reducing the boredom and

anxiety that frequently triggers responsive behaviours. A consultant explained why

boredom in LTC typically causes responsive behaviours and how MMD activities provided

a means for residents to re-engage in life:

> *C2: … even though the Montessori concepts are dementia-specific, I feel the philosophy behind it could be meaningful to anyone because anyone who is showing behaviours in the nursing home, they're showing behaviours because their needs are not met, they are frustrated, they feel bored, and they have no control … if they're engaged in activities that are of interest to them and have a role to function in then that will make a difference … I see people just sitting in the hallways waiting after breakfast they are waiting for another meal to happen, nothing happens in between. There are recreational activities but not enough, they are really not as much as they should be … people who didn't have behaviours before can develop behaviours because they are so bored, they are so disengaged in life, they're just existing rather than living.*

Another consultant similarly described how she saw MMD enrich the quality of life of

both residents and staff by giving residents activities and roles that they enjoyed:

> *C1: … a lot of times you would see the residents sitting bored or coming up to the desk and repetitively asking questions of the staff and the staff are getting frustrated where now the staff, you know, can give these residents something to do where they feel useful and they're enjoying their time as opposed to um, you know, maybe looking for negative attention.*

Another consultant (C3) commented on how MMD enhanced the quality of life of

residents. She gave an example of how providing a resident with a MMD activity based on

her former role as a teacher helped to relieve her anxiety:

> *C3: ... if we reduce their anxieties by giving them purposeful work that helps their quality of life. Rather than Mrs. Smith sitting there calling out, calling out, calling out, allowing her, she's been calling out because she was a teacher and students should be doing something, then giving her something that will keep her occupied and purposeful from being a teacher, that's definitely quality of life.*

Likewise, a recreation assistant noticed that since using MMD activities in her LTC home the quality of life of residents had improved:

> *R10: We have residents who are more engaged in activities, we have residents who will initiate or do independent activities. Residents that would be calling out, you know, we were able to help them out a little bit.*
> *I: So they don't call out as often?*
> *R10: They don't call out as often, yep. Less rummaging through other rooms and things like that.*
> *I: Oh alright. And what would you attribute that to if they're doing, you know, less rummaging and calling out?*
> *R10: Because we've engaged them, I don't think they've been able to reach a point where they need to, where they exhibit behaviours, if we get, can keep them engaged ... because there's maybe less boredom they're not calling out. I think that's a better quality of life.*

5.7.3 Improving Residents' Quality of Life Summary

In summary, the theme Improving Residents' Quality of Life portrayed how participants used MMD to facilitate residents' involvement in daily activities, roles and relationships which improved their quality of life and reduced the boredom and anxiety that they typically experienced. Participants found that residents with dementia were more engaged with MMD activities since they are customized to meet their personal needs and interests and increase their independence. Overall, they witnessed positive reactions from residents participating in MMD activities and daily life in the home which resulted in less responsive behaviours.

5.8 Results Summary

Overall, the thematic findings indicate that there are culture change tensions between limiting factors as well as enabling factors affecting MMD implementation in Ontario LTC homes. The enabling factors contributed to positive outcomes for residents with dementia, staff and family members. It is clear that barriers had to be overcome and various forms of support provided beneficial results, thus encouraging staff and families to continue using MMD approaches with residents with dementia. The limiting factors comprise the theme Regulating and Funding Medical Practices where participants described how Ministry regulations and funding contributed to medicalized and task-oriented LTC practices. The theme Shifting Practice Amidst Resistance to Change reflects the culture change tensions in LTC homes that staff reported. Enabling factors are denoted within the themes Educating and Understanding, Seeing Results is Believing, and Being Supported. These enabling factors led to several positive outcomes as a result of MMD which were identified in the themes (Re-)Connecting People and Passions, and Improving Residents' Quality of Life. The limiting factors, LTC culture change tensions, enabling factors, and positive outcomes will be discussed in more detail regarding the study's research questions in the following section.

6.0 Discussion

This section discusses the results of this study in relation to existing research, followed by implications, study limitations, and suggestions for future research.

6.1 Discussion of Results in Relation to Existing Research

This study's five research questions are discussed below in relation to existing research and identified themes to reveal common findings as well as new insights into staff perceptions of factors affecting the implementation of MMD in Ontario LTC homes.

6.1.1 What are Staff's Perceptions of the Factors that Affect the Implementation of MMD in Ontario LTC Homes?

Staff's perceptions of the factors that affect the implementation of MMD in Ontario LTC homes reveal that there are culture change tensions between limiting factors and enabling factors. Positive outcomes that improved the quality of life of residents with dementia, staff and family members were possible when sufficient support was available to recreation staff. These findings are depicted as a conceptual model in Figure 1 on page 124. Staff's perceptions were revealed during thematic analysis and will be described in relation to the resultant themes below.

The limiting factors are encompassed in the theme Regulating and Funding Medical Practices where Ministry regulations and funding contributed to the medicalized and task-oriented LTC practices that participants described. All staff in LTC homes were driven by Ministry regulations which places a priority on attending to the medical status of residents rather than ensuring their quality of life. Similarly, these regulations and practices seemed to create a hierarchy in LTC homes where the task-oriented caring roles

of nursing staff were more important than the person-centred activities such as MMD that recreation staff provided. This resulted in the importance of activities such as MMD and the recreation staff who facilitate them being underestimated. Recreation staff were not viewed as professionals by nursing staff who would try using MMD at the expert advice of consultants. Participants also noted how Ministry funding regulations were insufficient for their staffing ratios, materials, and educational needs to provide residents with dementia with individualized and beneficial MMD activities.

Regarding culture change tensions in LTC homes, the theme Shifting Practice Amidst Resistance to Change depicted how recreation staff wanted to transition to smaller more effective quality programming using MMD because traditional large group activities were not well-suited for the unique needs and abilities of residents with dementia. While shifting their programming practices, recreation staff encountered resistance to change from staff and family members who were used to residents being together in large group activities as well as from recreation staff who were taught that large social events are best.

Enabling factors consist of the themes Educating and Understanding, Seeing Results is Believing, and Being Supported. Educating and Understanding denoted how staff and family needed to be educated on the philosophy, use and benefits of MMD in order to understand why recreation staff were using it with residents. This helped to change the negative attitudes toward MMD and activities that some staff and family members had while highlighting the benefits of meaningfully engaging residents with dementia with activities and its usefulness for staff. Staff and family members could be educated by taking the MMD workshop off-site or they could be informed about it in their

LTC home through in-services or other group or one-on-one education sessions facilitated by consultants or recreation staff. Seeing Results is Believing detailed how some staff and family members needed to witness the positive effects of MMD for themselves in order to be convinced that it works which then made it easier for recreation staff to put into practice. The main impressive results that changed sceptical attitudes were seeing residents with dementia become more engaged in activities and daily life in the home as well as seeing MMD assist with responsive behaviours. Being Supported specified the various forms of support that participants required to put MMD into practice. Support from staff and colleagues, management, consultants and family members helped recreation staff implement MMD for the benefit of residents with dementia and their relationships with those who work with and visit them.

These enabling factors led to many positive outcomes as a result of MMD which were identified in the themes (Re-)Connecting People and Passions, and Improving Residents' Quality of Life. (Re-)Connecting People and Passions captured how staff were able to foster meaningful connections with residents with dementia using MMD activities and how it reconnected them with their confidence, passion and purpose for wanting to work in LTC. MMD activities also facilitated meaningful family-resident connections which improved their relationships. Another positive outcome of implementing MMD in Ontario LTC homes is that it improved residents' quality of life by providing them with activities and roles and improved their relationships which enabled them to enjoy life again. The quality of life of residents with dementia was also improved through the

reduction in boredom as a result of engaging in MMD activities which reduced the responsive behaviours that staff observed.

In summary, there were culture change tensions between the limiting factors and enabling factors that affected the implementation of MMD in Ontario LTC homes. The enabling factors facilitated beneficial outcomes for residents with dementia, staff and family members. The limiting factors were largely structural challenges or barriers that participants were able to overcome with the organizational, financial, educational and individual support of staff, management, consultants and family members. Enlisting sufficient support enabled recreation staff to put MMD into practice which improved the quality of life of residents with dementia, the staff who work with them as well as family members. These factors, tensions and outcomes will now be discussed in relation to existing research in response to the study's other research questions.

Figure 1 – Implementing MMD in Ontario LTC Homes Conceptual Model

LIMITING FACTORS

Regulating and Funding Medical Practices
- Ministry Regulations Help Create Medicalized & Task-Oriented LTC Practices
    - LTC staff were driven by Ministry regulations
    - Nursing staff were task-oriented
    - Medical priority over quality of life in LTC
- Medicalized LTC Leads to Staff Hierarchy
    - Disrespecting & undervaluing recreation and MMD
    - Unwillingness of nursing staff to participate in recreation programming
    - Consultants given more legitimacy as "experts" by nursing staff
- Limited Ministry Funding
    - Insufficient funding for program materials
    - Insufficient funding for adequate staff-to-resident ratios
    - Insufficient funding for staff training

ENABLING FACTORS
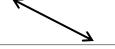
Educating and Understanding
- Addressing Negative Attitudes through Increased Understanding
- Highlighting the Usefulness of MMD for Staff
- Experiencing MMD Training First-Hand
- Bringing MMD Education to the LTC Home
    - Educating staff via in-services
    - Educating staff via consultants
- Educating Families

Seeing Results is Believing
- Seeing Positive Results for Residents
- Seeing MMD Assist with Responsive Behaviours
- Families Noticing Positive Changes

Being Supported
- Finding Support & Learning from Staff & Colleagues
- Being Supported from the Top
- Drawing on Consultant Support & Resources

LTC CULTURE CHANGE TENSIONS

Shifting Practice Amidst Resistance to Change
- Transitioning to Smaller More Effective Quality Programming
- Encountering Resistance to Change

POSITIVE OUTCOMES

(Re-)Connecting People and Passions
- Fostering Meaningful Connections with Residents
- Facilitating Meaningful Family-Resident Connections
- Reconnecting with Confidence, Passion & Purpose for Working in LTC

Improving Residents' Quality of Life
- Enabling Residents to Enjoy Life Again
- Reducing Boredom & Meeting Individual Needs

6.1.2 What are the Challenges that Staff Experience When Implementing MMD in Ontario LTC Homes?

The main challenges that staff experienced when implementing MMD in Ontario LTC homes were related to Ministry regulations, which is well-supported by existing literature. In particular, there is a large body of related research on the structural factors that inhibit the use of person-centred care as well as the organizational and individual factors that participants described. Overall, participants recounted how the extensive number of regulations in the Long-Term Care Homes Act (MOHLTC, 2011c) contributed to medicalized and task-oriented LTC practices rather than person-centred practices which facilitated the implementation of MMD.

Participants reported how staff were driven by Ministry regulations which coincides with previous work that found LTC regulations encourage staff to attend to residents' bodily needs appropriately, safely and cost-effectively, resulting in residents becoming objectified by staff and in-house policies (Lanoix, 2005; Wiersma & Dupuis, 2010). Participants feared contradicting Ministry regulations so that they would not be sanctioned by management or government inspectors which concurs with research done by Kontos and colleagues (2010) as well as accounts from other MMD workshop participants (Elliot, 2011). Staff's preoccupation with meeting Ministry standards and the physical needs of residents made it difficult to provide them with the emotional and relational aspects involved with person-centred care as was similarly reported in a comprehensive literature review by Nolan and colleagues (2008). This was likely the reason why participants found that nursing staff were task-oriented and not willing to incorporate Montessori-based principles or activities into their work with residents. Research by

Wiersma and Dupuis (2010) also found that caring work in LTC is primarily task-oriented rather than person-centred as nursing staff reported that there is not enough time, training or staffing to enable them to provide quality care (Dupuis & Wiersma, 2006, 2007). Therefore, nursing staff likely resort to their biomedical training and Ministry regulations which encourage them to care for residents' physical aspects of daily living and not their psychosocial ones (Brooker et al., 2007).

The medical priority over quality of life in LTC not only made it difficult for nursing staff to meet the needs of residents more holistically in a person-centred manner, it also seemed to contribute to the sense that nursing staff and duties were more important than recreation staff and activities. Staff hierarchies in LTC homes are not compatible with person-centred care which requires shared decision making and power among everyone who works and lives there, thus necessitating beneficial staff relationships and encouraging innovation (McCormack et al., 2010; McCormack & McCance, 2006). The valuing of medical practices over other aspects of life in LTC likely contributed to staffs' attitude that activities should only be provided by recreation staff in large group formats and the resistance that nursing staff felt toward being involved with them which was also found in previous studies (Skrajner et al., 2007; Volicer, et al., 2006). The disrespect and undervaluing of recreation staff and MMD activities is probably due to a lack of knowledge about the importance of activities and MMD in LTC as evidenced in other research (Dupuis et al., 2003; Elliot, 2011; Smith, 2004). The fact that nursing staff did not regard recreation staff as professionals could also be because recreation is not a regulated profession in Ontario whereas nursing is (Smith, 2004).

The Ministry's propensity to regulate and fund medical practices in LTC likely contributed to recreation staff reporting that they did not have sufficient finances to purchase materials for activities and hire and train staff. Insufficient funding was also reported by Dupuis and colleagues (2003) to be one of LTC recreation staff's main challenges as well as by previous MMD workshop participants (Elliot, 2011) and other program implementation research (Nolan et al., 2008; Stolee et al., 2005). Lack of funding also contributed to the inadequate recreation staff-to-resident ratios that participants described as this reduced their ability to provide residents with personalized MMD activities. Very low recreation staff-to-resident ratios in LTC have also been found in previous research (Dupuis et al., 2003; Sharkey, 2008; Smith, 2004) as have inadequate LTC staffing levels and high workloads (Aylward et al., 2003; Nolan et al., 2008; Stolee et al., 2005). Low recreation staff-to-resident ratios tends to result in less residents participating in activities (Dupuis et al., 2003) whereas higher staff-to-resident ratios enable staff to provide more individualized activities, such as MMD, that match the needs and abilities of persons with dementia (Volicer et al., 2006). Insufficient funding to send recreation staff for MMD training was another impediment to implementing MMD in LTC as they generally do not have access to continuing education funds through their professional associations (Smith, 2004). In general, LTC homes in Ontario are under-funded which makes attending any form of training difficult (Stolee et al., 2005) as was found in this study.

Aside from Ministry regulations, another challenge that staff experienced was resistance from staff and families when transitioning from large group to small group or

one-on-one MMD activities. Traditional LTC programs generally involve large numbers of residents which participants found were not appropriate for residents with dementia and not consistent with person-centred care. Participants wanted to transition from the traditional large group activities commonly used in LTC homes to smaller group or one-on-one MMD activities as they best met the unique needs and abilities of residents with dementia. Previous research identified that LTC recreation staff usually facilitate group activities which can be difficult for persons with advanced dementia to participate in, especially in large groups (Giroux et al., 2010; Orsulic-Jeras et al., 2000; Volicer et al., 2006). As reported by participants, staff and family members were used to residents being together during large group activities, and even some recreation staff were taught that a large social format was best for residents. Although the resistance that participants experienced when transitioning from large to small group or one-on-one activities in LTC was not found in existing literature, it highlights how pervasive individual attitudes and organizational practices can be and the culture change challenges within LTC homes. This is related to the following discussions regarding the need for staff and family members to be educated on MMD and the various forms of support, especially organizational support, that recreation staff require in order to successfully put MMD into practice.

6.1.3 What are the Benefits that Staff Experience When Implementing MMD in Ontario LTC Homes?

The benefits that staff experienced when implementing MMD in Ontario LTC homes were primarily how MMD enabled them to meaningfully connect with residents with dementia. By using MMD, recreation staff also reconnected with their passion for working in LTC and renewed their confidence in providing residents with dementia with

activities. Hence, these findings can be situated in the literature pertaining to the individual factors that can affect and result from person-centred program implementation in LTC.

Participants were able to foster meaningful connections with residents using MMD as it enabled them connect or re-connect with those that they previously had difficulty communicating with or finding an enjoyable activity for.   This aligns with person-centred care philosophy which values the need for social interaction and involvement in life that persons with dementia require regardless of their physical or cognitive abilities (Kitwood, 1997) as well as the interdependent relationships that they have with others as emphasized in relationship-centred care (Dupuis, Gillies et al., 2012; Nolan et al., 2002, 2004). Being able to connect with residents using MMD activities and witness its positive effects on residents' quality of life helped staff feel happy and confident in their abilities which reaffirmed their reasons for wanting to work in LTC. Similar findings were reported in a Canadian study regarding the perceived rewards of recreation staff in LTC homes (Dupuis et al., 2003). Zimmerman and colleagues (2005b) also found that having a person-centred attitude resulted in increased job satisfaction and confidence in providing dementia care.

Using a personalized approach, such as MMD, with persons with dementia more suitably meets their physical, cognitive, emotional and social needs and abilities (Buettner, 1999; Gerdner, 2000; Giroux et al., 2010; Kolanowski et al., 2005; Orsulic-Jeras et al., 2001; Russen-Rondinone & DesRoberts, 1996; Van Haitsma, 2000; Van Haitsma & Ruckdeschel, 2001). MMD activities enabled staff to provide residents with dementia with a more suitable approach, individualized attention, opportunities for interaction, and

adequate sensory and cognitive stimulation than traditional activities (Camp & Mattern, 1999; Judge et al., 2000; Orsulic-Jeras et al., 2001). This resulted in positive effects for residents such as increased engagement in activities and daily life in the LTC home and a reduction in boredom and anxiety. These were also beneficial for staff as participants reported that MMD saved them time in their daily work with residents. This is due to staff spending less time responding to behaviours as residents were more content and involved in activities rather than spending the majority of their time bored and alone as was found in previous research (Camp et al., 1996; Cohen-Mansfield, 2000; Dupuis & Luh, 2005; Giroux et al., 2010; Kolanowski et al., 2005; Logsdon, 2000; Schreiner et al., 2005).

6.1.4 In the Opinion of Staff, What are the Benefits for Residents with Dementia and Family Members Using MMD in Ontario LTC Homes?

The benefits perceived by staff for residents with dementia and family members using MMD in Ontario LTC homes were enhanced engagement in daily life and relationships. Residents' quality of life was improved through MMD as they became engaged in meaningful activities, roles and relationships which effectively reduced the boredom and fear that could trigger responsive behaviours. MMD also provided a means to increase their independence and maintain and regain their skills. Family members used MMD to meaningfully connect and enjoy quality visits with their relatives.

Overall, participants noticed that MMD enabled residents with dementia to enjoy life again as it increased their involvement in daily activities. This corresponds with previous research which also found that using Montessori approaches with persons with dementia can increase their amount of active engagement in and enjoyment of activities (Camp et al., 1997; Camp & Mattern, 1999; Giroux et al., 2010; Jarrott et al., 2008; Judge

et al., 2000; Orsulic-Jeras et al., 2000; Schneider & Camp, 2002; Vance et al., 1996).

Similarly, research by Giroux and colleagues (2010) reported that activities which match

the interests of persons with dementia fulfill their basic psychological needs for self-

esteem, accomplishment and well-being, thus improving their quality of life. Hence,

MMD activities in LTC can be considered a form of person-centred care as they

incorporate the resident's perspective, well-being, strengths, dignity and independence in a

therapeutic environment (Brooker, 2004; Dupuis, Wiersma et al., 2012; Edvardsson et al.,

2008; McCormack et al., 2010; McCormack & McCance, 2006).

Not only did MMD activities help increase residents' enjoyment of life, it also

improved the quality of it by reducing the boredom and anxiety that tend to trigger

responsive behaviours. Participants attributed the decrease in responsive behaviours that

they observed to residents being meaningfully engaged in MMD activities and life in the

LTC home. A study by Schreiner and colleagues (2005) found that residents with

dementia typically spent 60% of their day alone, doing nothing 49% of the time, whereas

they were seven times more likely to appear happy during an activity with 44% of

residents appearing happy only during that time. Likewise, the perceived beneficial effects

that MMD activities had on residents with dementia as described by participants is also

supported by the literature. Montessori approaches have been found to decrease

behaviours such as agitation and social withdrawal, and lower feelings of fear, anger and

anxiety experienced by persons with dementia (Camp et al., 1997; Camp & Mattern, 1999;

Giroux et al., 2010; Jarrott et al., 2008; Judge et al., 2000; Orsulic-Jeras et al., 2000;

Schneider & Camp, 2002; Vance et al., 1996). Similarly, recreational activities in LTC

can reduce residents' anxiety, agitation, and depression (Buettner, 1995, 1999; Buettner & Ferrario, 1997; Buettner & Fitzsimmons, 2002; Fitzsimmons, 2001; Rosling & Kitchen, 1992; Ward et al., 1996). As reported by participants and in the literature, providing residents with dementia with activities that match their interests and abilities helps reduce responsive behaviours and improve their quality of life (Camp et al., 1996; Giroux et al., 2010). Thus, research supports participants' observations that the boredom and isolation that residents with dementia experienced when not involved in a meaningful activity could lead to behavioural responses (Cohen-Mansfield, 2000; Dupuis & Luh, 2005; Logsdon, 2000).

Residents' quality of life was also enriched through engagement in meaningful roles and relationships, and maintaining and regaining their skills using MMD activities. Participants stated how MMD enabled residents with dementia to sustain and improve their cognitive and communication skills, such as by reading, writing, conversing, and participating in activities with staff and family members. These skills enhanced their relationships and sense of community within the LTC home as they were able to continue duties and roles that they previously had before moving into LTC such as cleaning, homemaking, mothering, teaching and delivering mail. Participants also recounted how residents with dementia increased their independence with eating through the use of MMD task breakdown principles where the steps involved with eating were made more clear and manageable, as well as individualized scooping activities that enabled residents to regain and maintain the dexterity to use utensils. As was found in previous research, these beneficial recreational activities for residents with dementia: developed their sense of

belonging and community (Coppola et al., 1990; Sullivan et al., 2002); improved their physical and cognitive functioning (Buettner, 1988); created more opportunities for social interactions (Crispi & Heitner, 2002; Katsinas, 2000; Trzinski & Higgins, 2001); and enhanced their feelings of autonomy, control and self-esteem (Card, 1989; Duncan-Myers & Huebner, 2000; Lilley & Jackson, 1990; Martin & Smith, 1993; Phinney et al., 2007; Shary & Iso-Ahola, 1989; Voelkl et al., 1995).

Family members were also able to use MMD activities to meaningfully connect with their relatives. Participants reported that family members sometimes found visiting their relatives in LTC difficult but that MMD provided a means to have a quality visit. Literature supports this finding as research by Schneider and Camp (2002) noted that Montessori-based activities gave family members a meaningful role and a means of communicating with their relatives with dementia which reduced their self-reported burden. Schneider and Camp (2002) also found that Montessori-based activities were conducive to positive, interactive family visits as they increased residents' engagement as well as the beneficial changes that their family members observed during activities. In general, providing family members and residents with activities can improve the quality of their visits and their relationships (Dupuis & Pedlar, 1995).

6.1.5 What are the Supports Available to or Needed by Staff, Residents with Dementia and Family Members Who are Using MMD in Ontario LTC Homes?

The supports available to or needed by staff, residents with dementia and family members who are using MMD in Ontario LTC homes include educational, organizational, financial and individual support. The findings that pertain to educational support have a

firm base within related literature, especially regarding organizational and individual support. Implementing MMD activities with residents in LTC required staff and family members to be educated on its purpose, methods and benefits so that they were more likely to use it themselves or at least support the staff members who use it.

Participants encountered negative or indifferent attitudes toward MMD and activities when implementing it but found that these could be changed by providing staff and family members with information on how it works and why it was beneficial to use with residents. Benefits included not only positive results for residents, but also for staff in terms of saving them time in their daily work with residents. This is similar to previous findings where MMD workshop participants reported that a lack of knowledge about the program, its benefits and effectiveness were an impediment to implementing it in various care settings (Elliot, 2011). Likewise, this corresponds with other accounts regarding the dearth of information that staff in LTC possess about the advantages of activities for residents (Dupuis et al., 2003; Smith, 2004). Since LTC is primarily a medical environment, staff need to know what person-centred care is, why personalized activities such as MMD are important, and how to put them into practice in order for staff to shift from a biomedical model of care to a person-centred one (McCormack & McCance, 2006).

Experiencing MMD training first-hand at an off-site two-day workshop was beneficial for participants as they comprehensively learned about its theory and methods with ample time to practice what they learned and receive feedback. MMD workshops educate participants using multiple means of disseminating the information as supported in the literature. This includes lectures, videos, booklets, and applied practice so that it can

effectively change the person's attitudes and knowledge (Aylward et al., 2003; Green & Kreuter, 1991; Skrajner et al., 2007). MMD is provided in a standardized yet flexible format by instructors to ensure consistent delivery (Fletcher et al., 2010) with a credentialing system for participants (Hyer et al., 2010). According to statistics, mainly recreation staff from LTC homes attend MMD training (Elliot, 2011), which corresponds with the predominance of recreation staff in this study. This is likely because recreation staff in LTC homes are the largest group of activity providers working with persons with dementia in Ontario.

Participants found that they could bring MMD education to their LTC home in order to educate staff who did not have time to attend the two-day MMD workshop off-site or who could not afford it. Recreation staff primarily used in-services as the way of educating other staff in the LTC home on MMD which either they or a consultant facilitated. Having MMD trained staff conduct in-house educational sessions for other staff reinforces findings in the literature that suggest leaders or mentors in LTC can assist with the application of new knowledge and its long-term sustainability (McCainey et al., 2007; Nolan et al., 2008; Stolee et al., 2005, 2009). Holding multiple education sessions and refreshers has also been identified as way to increase a program's retention and application in the workplace (Gould & Reed, 2009; Hyer et al., 2010; McCabe et al., 2007; Moyle et al., 2010; Rampatige et al., 2009). Furthermore, conducting staff in-services or one-on-one MMD education sessions with consultants helped put MMD into practice which is supported by the literature as on-going expert follow-up assistance can effectively increase the uptake of education in LTC (Stolee et al., 2005).

As with the MMD education methods that staff used, families can also be educated on how to use it with their relatives through in-services or educational sessions either through the MMD workshop or at the LTC home. Some participants in this study provided family members with group or one-on-one MMD education sessions in the LTC home which is akin to previous research (Dupuis et al., 2003; Hellen, 1998; Smith, 2004). This helps family members to continue their active caring roles and involvement in their relatives' lives (Bowers, 1988; et al., 1993; Dupuis & Norris, 1997; 2001; Rubin & Shuttlesworth, 1983; Schwartz & Vogel, 1990; Shuttlesworth et al., 1982; Zarit & Whitlatch, 1992).

Like educational support, the other methods of assistance participants described correspond with findings reported in other studies, mainly in terms of organizational support but also individual support. Recreation staff found various forms of support within the LTC home through other staff, colleagues, management and families and externally from consultants. They received enthusiastic support from staff within their department which aligns with literature that identified the need for collegial support in order to put new knowledge into practice in LTC (Aylward et al., 2003; Green & Kreuter, 1991; McCainey et al., 2007; Nolan et al., 2008; Stolee et al., 2005, 2009) and the belief that activities should be implemented by recreation staff (Skrajner et al., 2007; Volicer, et al., 2006).

Aside from being supported by their colleagues, participants described how receiving support from management in the LTC home was a practical way to help implement MMD. Managers provided support by asking their staff to be cooperative,

offering financial support as well as personal support in the form of encouragement. There is extensive comparable data in the literature which identifies organizational support as a key factor to program implementation in LTC. Managerial support and long-term culture change have been found to determine whether person-centred programs such as MMD are put into practice in LTC more so than peer support (Garbett & McCormack, 2002; McCormack et al., 2008; 2010; McCormack & McCance, 2006; Murphy et al., 2007) which is consistent with similar findings regarding implementing and sustaining educational programs in LTC and the knowledge learned from them (Aylward et al., 2003; Beeber et al., 2010; Cerveo, 1985; Corazzini et al., 2010; Green & Kreuter, 1991; Kuske et al., 2007; McCabe et al., 2007; Mitchell et al., 2010; Moyle et al., 2010; Murphy, 2007; Nolan et al., 2008; Skrajner et al., 2007; Stolee et al., 2005; 2009). This is because organizational policy and practice changes are needed to accommodate the new knowledge and practices among staff, such as prioritizing and funding training, providing materials, and adjusting staff's schedules as needed (Nolan et al., 2008; Skrajner et al., 2007; Stolee et al., 2005). Management styles are other organizational factors that can affect the application of new knowledge and programs in LTC such as MMD as they can maintain task-oriented and hierarchical practices (Bishop et al., 2008; Corazzini et al., 2010) or they can be flexible and empowering to facilitate the individualized care and activities involved with person-centred care (Bishop et al., 2008; Cohen-Mansfield & Bester, 2006; Corazzini et al., 2010; Murphy et al., 2007). Managers can also help reduce the hierarchies between nursing and recreation staff identified by participants and encourage multi-disciplinary cooperation and team-building by sending staff from various disciplines to the MMD

workshop which would also increase its awareness and use throughout the LTC home (Skrajner et al., 2007; Smith, 2004; Volicer et al., 2006).

Similarly, finding support from consultants was reported to cultivate relationships between staff in different disciplines in the LTC home as well as between recreation staff and management. Consultants described how they supported and educated staff and management regarding MMD by sharing their ideas, expertise and materials. This form of expert support corresponds with findings in the literature which recommended that LTC homes have mentors to ensure new knowledge is sustainably put into practice (McCainey et al., 2007; Nolan et al., 2008; Stolee et al., 2005; 2009).

The assistance of families was also useful for putting MMD into practice as they engaged their relatives in activities, helped pay for the cost of materials and gave their personal support to participants during meetings. Family members are an important partner in care in LTC and so activities help to build their rapport with staff as well as maintain their relationships with their relatives (Hellen, 1998; Schneider & Camp, 2002). As recommended by previous research (Dupuis et al., 2003; Hellen, 1998; Smith, 2004), participants organized MMD activities that family members could participate in with their relatives.

Another form of individual support advantageous for those using MMD in Ontario LTC homes was to have sceptics witness the beneficial results of MMD. Although staff and family members' attitudes toward MMD were effectively changed by seeing its positive results for themselves, there is no LTC program implementation literature which yielded comparable results. This finding reveals the individual nature of belief and

acceptance. It is similar in a way to educational support as seeing results led to the perception or understanding that MMD works which then made it easier for recreation staff to implement and other staff and family members to use with residents. But participants reported that educating about and witnessing the effects of MMD were two different means of encouraging staff and family members to support its use in LTC. This information may be useful for those implementing MMD in LTC homes who found that education alone did not sufficiently increase the buy-in or cooperation from other staff and family members.

6.1.6 Discussion Summary

This discussion reveals how ingrained individual beliefs and organizational practices are within LTC homes and how they can affect MMD program implementation. LTC organizational practices are largely determined by the Ministry's regulations and funding mechanisms which are structural factors. The medical structure of LTC prescribes how management should organize their LTC homes, which affects the organizational culture and practices that staff engage in and the attitudes they have toward residents, other staff and families. Basically, the structural valuing of the medical needs of residents over their quality of life greatly influences organizational and individual practices within LTC homes. Thus, organizational support is required to change the attitudes of staff to a person-centred culture of care which can be furthered with the assistance of staff, consultants and family members. Witnessing the positive effects that MMD had on residents with dementia was another way that beneficially altered sceptical, unsupportive individual beliefs. Support from staff, consultants and family members can be facilitated using education on MMD and its methods, uses and benefits for everyone in LTC homes.

Although family members were participants' main source of financial support, consultants were also able to secure funding through their expert status with LTC management. Participants reported that individual and organizational change was possible but that structural change was not. This is likely because the participants had more influence on and support from others at an individual and organizational level. Overall, recreation staff required sufficient organizational, financial, educational, and personal support in order to successfully implement MMD in LTC homes.

6.2 Implications

The results from this study are useful for residents with dementia, family members and LTC staff, especially recreation staff. MMD provides a means for residents with dementia to be meaningfully and actively engaged in life in LTC and for others to partner with them achieve this. As such, there are several implications for those who live in, work in and visit LTC homes as well as for those who determine LTC policies, such as management and the Ministry of Health and Long-Term Care. There are also theoretical implications pertaining to the political economy of aging.

6.2.1 Implications for Residents with Dementia

➢ Residents with dementia want to be engaged in daily activities, relationships and in life in their LTC home so that they are not spending their days bored and alone.

- ➢ MMD activities facilitated in a small group or one-on-one setting are better suited to the individual needs, interests and abilities of residents with dementia than traditional large group LTC activities.
  - MMD activities provide meaningful ways for residents with dementia to maintain engagement in life.
- ➢ Residents with dementia can experience an improved quality of life and may be less likely to communicate unmet needs through responsive behaviours using MMD approaches and activities.
- ➢ Residents with dementia can encourage their LTC home to use MMD activities during Resident Council meetings or by speaking with the home's administrator and recreation manager or their family members.
  - Residents with dementia can also request to receive information and education on MMD through an individual or small group session in the home.

6.2.2 Implications for Family Members

- ➢ Family members want to be involved in their relatives' lives in LTC and need ways to have a quality visit.
- ➢ Family members can use MMD activities when visiting their relatives in LTC homes to meaningfully connect with them and have a quality visit.
  - Family members can ask LTC recreation staff about receiving education on how to use MMD activities through an individual or group training session in the home.

- If the home does not offer MMD activities or education, family members can encourage the home's administrator and recreation manager to look into MMD workshop training for its recreation staff or request the assistance of an outside consultant to facilitate a MMD in-service for staff and families.

- Family members can also learn more about MMD by taking the two-day workshop or speaking with consultants, such as those who work at an Alzheimer Society.

➢ Family members can help staff implement MMD in LTC homes by engaging their relatives with MMD activities, providing financial support, and also offering personal support during care conferences or Family Council meetings.

6.2.3 Implications for LTC Staff

➢ Recreation staff in LTC homes want to engage residents with dementia in activities that are meaningful and interesting to them and are well-suited to their needs and capabilities but need more education and various forms of support to do so.

➢ Recreation and other LTC staff can use MMD activities to engage residents with dementia with meaningful activities that correspond to their needs, interests and abilities.

➢ Recreation staff can implement MMD in LTC homes by:

- Beginning with a few residents with dementia and then incrementally expanding the program.

- Educating other staff, management, family members and residents on its methods and usefulness for residents with dementia, staff and family members through in-services or individual education sessions with the assistance of consultants.

- Finding personal and financial support from consultants, colleagues, management, staff from other departments and family members as necessary.

  - This could include having consultants work with management and staff from other departments, enlisting the support from family members during Family Council meetings and residents during Resident Council meetings, and seeking advice from a professional association, such as Activity Professionals of Ontario or Therapeutic Recreation Ontario.

  - Consultants can help obtain financial support from management and family members or other sources.

- Demonstrating its positive effects to other staff, management, residents and family members by having them witness the effects for themselves or documenting its effects as proof.

6.2.4 Implications for LTC Policy

➤ Increase the amount of funding for recreation staff in LTC homes so that they are adequately staffed and have sufficient materials and education budgets to provide residents with dementia with meaningful and beneficial MMD activities and person-centred care.

➤ Provide LTC managers and Ministry policy makers and inspectors with education on person-centred care.

➤ Ensure Ministry inspectors investigate whether LTC staff and management are correctly perceiving or interpreting Ministry regulations in order to resolve any misunderstandings that hinder person-centred care and MMD.

➤ Encourage person-centred practices and activities such as MMD in LTC so that residents' quality of life is considered as important as their medical or physical status by all staff, management and family members.

- This could be achieved through mandatory, funded person-centred education that emphasizes the importance of residents' quality of care and quality of life, and supporting initiatives that foster the social aspects of care and living in LTC homes.

➤ Encourage LTC homes to reduce staff hierarchies and encourage team-building so that all disciplines, departments, family members and residents are considered valuable partners in care.

- This could also be achieved through mandatory, funded team-building exercises and education using an authentic partnership approach

(Dupuis, Gillies et al., 2012) that emphasizes the importance that all

staff, family members and residents have on life within LTC homes.

6.2.5 Political Economy of Aging Theoretical Implications

The political economy of aging theoretical perspective (Estes, 2001) was used

during this study to guide the investigation of staff perceptions of factors that affect the

implementation of MMD in Ontario LTC homes. It highlighted the multilevel and

interdependent relations between how individuals, organizations, institutions, social

policies, and social structures influenced putting MMD into practice. It also assisted with

revealing how pervasive medical policies, practices, and beliefs are within LTC homes and

how the biomedical culture of care affects residents with dementia, staff and family

members and seemingly creates resistance to new cultures of care such as person-centred

care. This was reflected in the culture change tensions between the traditional, task-

oriented biomedical model care, which focuses on the physical aspects of care, and the

relational, holistic aspects of person-centred care that participants described when

implementing MMD.

Facets of the political economy of aging that were not thoroughly utilized during

the analysis of this research were the public/citizen, the sex/gender system, and the social

constructions of older adults. The role of the public/citizen was not employed to reveal

how individuals broadly affect LTC policy locally, provincially and nationally. Rather, it

was used on to ascertain how residents, staff and family members are affected by LTC

policies and how they individually and collectively can contribute to person-centred

culture change by using MMD in LTC homes. As well, the sex/gender system could have

been analyzed more regarding how the majority of residents in LTC homes are women

who are cared for mainly by women, which is reflective of the fact that all participants in

this study were women. It was not used to investigate how gender roles and inequalities

could contribute to the treatment and experience of women living in, working in and

visiting LTC homes and the creation of LTC policy. Finally, the social constructions of

older adults were not fully examined in this study which would be useful for understanding

how staff, family members and LTC policy makers view older adults and particularly those

with dementia. These considerations indicate that although the political economy of aging

is a very comprehensive and useful theory, its breadth is difficult to fully explicate in

cross-sectional research studies. This information could be helpful for other researchers to

be aware of.

6.3 Limitations

There were several limitations to this study which are important to note. First of

all, the persons who participated in it were predominantly recreation staff. Most

consultants (60%) were nurses or a medical health professional and one recreation staff

member previously was a nurse. Thus, the views of recreation staff were mainly

ascertained which led to a narrow perspective and understanding of nursing roles and

implementing MMD in LTC. The reason for the sample being largely comprised of

recreation staff could be due to the fact that mainly recreation staff attend the MMD

workshop and facilitate activities in LTC (Elliot, 2011; Volicer et al., 2006). It would have

been useful to include the experiences of nursing staff members since they and recreation

staff frequently interact with residents and each other on a daily basis according to participants. As well, the experiences of residents and family members were reported based on the observations of participants so it would have been more beneficial to obtain their views by interviewing them.

Another potentially limiting consideration regarding the participants is the amount of time that they worked directly with residents. Sixty-seven percent of the recreation staff interviewed were recreation managers who, on average, spent 29% of their time working directly with residents while the remainder (33%) were recreation assistants who spent about 91% of their time working with residents. Consultants reported spending roughly 27% of their time working directly with residents since they mainly worked with LTC staff. Although the majority of participants spent less than half of their time working directly with residents, they provided rich accounts of their own experiences of using MMD with residents as well as recreation staff's experiences that they observed. Nonetheless, the results may have more accurately depicted the experiences of staff implementing MMD in LTC homes if more staff who worked directly with residents were recruited.

Regarding recruitment, the method of selecting participants exclusively by email likely resulted in a limited segment of MMD workshop attendees responding since other attendees may not have email addresses, such as PSWs, whereas some may have been more responsive to participating in the study if they had been contacted by telephone and/or postal mail. Due to privacy, confidentiality and resource issues, the MMD workshop attendees were not able to be recruited using multiple methods, such as email,

telephone and/or postal mail, to ensure that a greater number of them were advised of the study (De Leeuw; 2005; Dillman, 2007). Thus, this recruitment method may also have contributed to the participants largely being recreation staff as the study's topic is more relevant to their work in LTC than other staff members.

Lastly, the themes were primarily devised and analyzed based on the sole work of the researcher although input was sought from her supervisor and thesis committee members and incorporated during the final stages of thematic creation. It could have been useful to have another person review the codes and themes during the initial thematic analysis stages as part of an inter-coder reliability check to assess whether their content accurately and representatively depicted the data (Silverman, 2010). This was not possible given the time and funding constraints as this was research was conducted as part of a master's thesis. The detailed guidelines for conducting thematic analysis by Braun and Clarke (2006) were rigorously followed by the researcher to ameliorate this limitation; in particular, the amount of time to conduct data analysis spanned the majority of the study with three months of intensive work on thematic analysis alone. Data analysis began when the first interview was conducted in mid-September 2011 and ended when the last full draft of the report was completed in September 2012. The researcher also has previous experience with thematic analysis (Ducak & Keller, 2011). Additionally, the themes identified by the researcher resonate with those identified by previous Montessori-based research (Skrajner et al., 2007), including those reported by other MMD workshop attendees (Elliot, 2011).

6.4 Future Research

This study highlights the need for additional research regarding implementing MMD in Ontario LTC homes as its results indicate that MMD has beneficial effects for residents with dementia as well as staff and family members. Since the views of recreation staff primarily comprised this study, it would be useful to obtain the views of other staff members. One of the disciplines that would be valuable to interview for a related study are nursing staff (including PSWs) since they and the medical nature of LTC were identified to be one of the largest barriers to implementing MMD in LTC homes. This would provide the perspectives of nursing staff so that their views and experiences could contribute to a greater understanding of their role in LTC and how it affects the implementation of MMD activities. It would be interesting to obtain the views of staff from other disciplines, such as housekeeping, dietary, social work and administration, as they also interact with residents, witness activities taking place in LTC, are familiar with staff hierarchies, and may find that MMD activities are a useful way to meaningfully engage with residents with dementia and encourage them to be part of the home's community. Additionally, staff members to be interviewed in future research should include more recreation staff who work directly with residents to ensure that their experiences correspond with those reported in this study as most participants did not usually work directly with residents.

The perspectives and experiences of residents with dementia should be included in future research as they are the ones who likely benefit the most from MMD activities in Ontario LTC homes. Although some residents with dementia may have difficulty communicating, researchers should still try to obtain their views. This could be done

through interviews if possible, using assistive devices such as communication boards or the assistance of family members. For persons with more advanced dementia, studies could be observational where the effects that MMD activities have on residents are assessed, such as their levels of enjoyment, agitation, engagement, passivity, etc., as other studies have done with Montessori-based activities (Camp & Mattern, 1999; Giroux et al., 2010; Judge et al., 2000; Orsulic-Jeras et al., 2000). Currently, an observational study measuring the effects that MMD have on residents at a LTC home in Toronto, Ontario is underway (G. Elliot, personal communication, July 30, 2012). Despite the challenges, including the perspectives of residents with dementia is important so that their voices and experiences are reflected in research and incorporated into LTC activities and policies.

In addition to residents with dementia, the views and experiences of their family members need to be included in future research. Family members can be 'forgotten clients' in LTC (Pratt et al., 1987) even though they are important partners in care who want to be involved in MMD activities with their relatives and pay for activity costs so that they can continue to have meaningful relationships with them. Ascertaining the views of family members would help ensure that a balanced perspective of everyone who lives and works in LTC homes and is involved with MMD activities is captured and put to practical use.

As well, it would be useful to acquire the perspectives of Ministry of Health and Long-Term Care staff in future research. Obtaining the views of Ministry staff, such as LTC inspectors, could help reveal the rationale behind some of the Ministry's regulations and funding decisions that participants considered barriers to implementing MMD.

Interviewing Ministry staff could lead to useful recommendations for LTC staff who encountered structural and organizational challenges while implementing MMD. Speaking with Ministry staff could clarify whether LTC staff and management are correctly perceiving or interpreting Ministry regulations, how to resolve misunderstandings, and what staff can do to put more person-centred activities, such as MMD, into practice in LTC. Thus, the perspectives of Ministry staff would contribute to a comprehensive understanding regarding the barriers and supports affecting the implementation of MMD in Ontario LTC homes.

Involving LTC staff members from various disciplines, residents with dementia, family members and Ministry staff in future research would provide a broader understanding of their perceptions of MMD which is consistent with the authentic partnerships approach advocated by Dupuis, Gillies and colleagues (2012). "An '*authentic partnership*' actively incorporates and values diverse perspectives and includes *all* key stakeholder voices directly in decision-making. It involves working *with* others, not *for* others" (Dupuis, Gillies et al., 2012, p. 436, original emphasis). Hence, using an authentic partnership approach in future research on MMD in Ontario LTC homes can reveal individual, organizational and structural perceptions which could be useful for enacting change among persons at these various levels (Dupuis, Gillies et al., 2012).

Regarding research methods, future studies could use a longitudinal design to more fully understand how activities were put into practice before MMD was introduced into the home, how MMD activities were implemented after staff returned from a MMD workshop, what effects they had on residents, staff, and family members, and the challenges and

supports everyone encountered. This would offer greater insight into the process of how to implement MMD in LTC homes as this study revealed more about the barriers, supports and outcomes regarding MMD implementation than the process involved with putting it into practice. It would also be interesting to study what the MMD implementation process, effects, challenges and supports were three months, six months, and annually post-MMD workshop. A longitudinal study might also offer insight into how long the decline associated with dementia could be delayed, since MMD aims to maintain and enhance the function of persons at any stage of dementia. A two-year study by Dr. Monica Marchese using mice with Alzheimer's disease theorizes that the enriched environment principles in MMD, such as improving the physical and social environment, have a positive effect on their sensory, cognitive and motor function as well as their behaviour (M. Marchese, personal communication, August 7, 2012; McMaster University, 2012). Using a longitudinal design could also enable a larger research team to be involved with the study so that more participants with various roles and perceptions of activities and MMD could be recruited using mixed methods and the data could be analyzed by more than one person (Silverman, 2010). Furthermore, having more time to try and recruit participants from northern Ontario would be useful since none from that vast area participated in this study.

Future research could also more closely investigate whether the size of a LTC home, its profit status, staff-to-resident ratios and its leadership or management affect how MMD are viewed by other staff and the ease of putting it into practice. Progress with implementing MMD could be improved with the aid of someone in a leadership or upper management position in order to reduce organizational and attitudinal barriers as the

findings of this study suggest. As well, the size of a LTC home, its profit status and staff-to-resident ratios could be factors that affect the ability of staff to put MMD into practice.

Other research found that LTC home size and profit status affect its organizational

structure, management priorities and staffing levels (Berta et al., 2005). Half of the

recreation staff participants in this study worked in a small LTC home (less than 150

residents) and half worked in a large LTC home (150 or more residents). Fifty-eight

percent of recreation staff worked in a for-profit home while 42% worked in a non-profit

home. The results of this study suggest that recreation staff face similar barriers and

supports regardless of the LTC home's size and profit status but perhaps it is easier to put

MMD into practice in a small LTC home than in a large LTC home since smaller homes

have fewer staff and residents. Adequate staff-to-resident ratios could also affect the ease

of putting MMD into practice. Therefore, more research needs to be done regarding these

factors to determine if or how they affect the implementation of MMD in Ontario LTC

homes.

Finally, since participants mentioned how MMD increased the independence of

LTC residents and how other staff members were more likely to support it if it reduced

their workloads, studying how MMD affects residents' independence with activities of

daily living would be practical. This could be particularly useful as a way to increase the

buy-in from nursing staff or other staff members who viewed MMD as a burden to their

daily work with residents. Several participants (C3, R2, R4, R7, R11, and R12) described

how MMD enabled residents with dementia to relearn to feed themselves either using task

breakdown, where the steps involved with eating are made more clear and manageable, or

using scooping activities that enabled residents to maintain the dexterity to use utensils. The results of studies investigating the effects that MMD have on residents' activities of daily living could benefit both residents and staff, help families feel more confident in the care being provided, and contribute to a general awareness that activities in LTC are not just a way to pass the time.

7.0 Conclusion

In conclusion, this study identified staff perceptions of factors that affect the implementation of MMD in Ontario LTC homes as there was no existing research on this topic. The themes and factors reported in this study reveal how ingrained organizational practices and individual beliefs are in LTC homes and how they can positively or negatively affect MMD program implementation. LTC culture change tensions seemingly exist between limiting factors and enabling factors; the enabling factors facilitated many perceived positive outcomes for residents with dementia, staff and family members. The limiting factors were largely structural challenges or barriers that participants were able to overcome with the organizational, financial, educational, and individual support of staff, management, consultants and family members. The findings from this study provide evidence that the principles used to create MMD activities and implement them as a person-centred philosophy of care are possible when staff have a clear understanding of why and how to put these methods into practice and work together as a team with sufficient support to do so. The results from this research can help ensure that MMD are as practical and easy to implement as possible despite perceived barriers so that persons with dementia in LTC and their partners in care can have a good quality of life. The findings include suggestions for future research, reducing staff hierarchies and ensuring there is sufficient organizational, financial, educational, and personal support.

8.0 References

Aylward, S., Stolee, P., Keat, N., & Johncox, V. (2003). Effectiveness of continuing education in long-term care: A literature review. *The Gerontologist, 43*(2), 259-271.

Banerjee, A., Daly, T., Armstrong, H., Armstrong, P., Lafrance, S., & Szebehely, M. (2008). *Out of Control: Violence Against Personal Support Workers in Long-term care*. York University, Toronto, ON. Accessed February 22, 2011, from, http://www.yorku.ca/mediar/special/out_of_control___english.pdf

Beeber, A. S., Zimmerman, S., Fletcher, S., Mitchell, C. M., & Gould, E. (2010). Challenges and strategies for implementing and evaluating dementia care staff training in long-term care settings. *Alzheimer's Care Today, 11*(1), 17-39.

Berta, W., Laporte, A., & Valdmanis, V. (2005). Observations on institutional long-term care in Ontario: 1996-2002. *Canadian Journal on Aging, 24*(1), 71-84.

Berta, W., Laporte, A., Zarnett, D., Valdmanis, V., & Anderson, G. (2006). A pan-Canadian perspective on institutional long-term care. *Health Policy, 79*, 175-194.

Bishop, C. E., Weinberg, D. B., Leutz, W., Dossa, A., Pfefferle, S. G., & Zincavage, R. M. (2008). Nursing assistants' job commitment: Effect of nursing home organizational factors and impact on resident well-being. *The Gerontologist, 48*(S.I. 1), 36-45.

Bowers, B. J. (1988). Family perceptions of care in a nursing home. *The Gerontologist, 28*(3), 361-368.

Bowie, P., & Mountain, G. (1997). The relationship between patient behaviour and environmental quality for the dementing. *International Journal of Geriatric Psychiatry, 12*, 718-723.

Boyatzis, R. E. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. Thousand Oaks, CA: Sage Publications.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Brooker, D. (2004). What is person-centred care in dementia? *Reviews in Clinical Gerontology, 13*, 215-222.

Brooker, D. J., Wooley, R.J., & Lee, D. (2007). Enriching opportunities for people living with dementia in nursing homes: An evaluation of a multi-level activity-based model of care. *Aging and Mental Health, 11*(4), 361–70.

Brookman, C. (2008, March). *Preparing for the epidemic of dementia and Alzheimer's disease*. Ontario Community Support Association presentation at the 2nd Annual Healthcare Safety Forum, Toronto, ON. Accessed February 20, 2011, from http://www.u-first.ca/pdfs/Dementiaepidempresentationrevised.pdf

Buettner, L. L. (1988). Utilizing development theory and adaptive equipment with regressed geriatric patients in therapeutic recreation. *Therapeutic Recreation Journal, 22*(3), 72-79.

Buettner, L. L. (1995). Therapeutic recreation as an intervention for agitation in persons with dementia: A case study for Mrs. M. *Therapeutic Recreation Journal, 29*(1), 63-69.

Buettner, L. L. (1999). Simple pleasures: A multi-level sensorimotor intervention for nursing home residents with dementia. *American Journal of Alzheimer's Disease, 14*(1), 41-52.

Buettner L. L., & Ferrario, J. (1997). Therapeutic recreation-nursing team: A therapeutic intervention for nursing home residents with dementia. *Annual in Therapeutic Recreation, 7*, 21-28.

Buettner, L. L., & Fitzsimmons, S. (2002). Adventure program: Therapeutic biking for the treatment of depression in long-term care residents with dementia. *American Journal of Alzheimer's Disease and Other Dementias, 17*(2), 121-127.

Butters, N., Delis, D. C., & Lucas, J. A. (1995). Clinical assessment of memory disorders in amnesia and dementia. *Annual Review of Psychology, 46*, 493-523.

Camp, C. J. (1999). *Montessori-Based Activities for Persons with Dementia (Vol. 1)*. Beachwood, OH: Menorah Park Press.

Camp, C. J. (2006). *Montessori-Based Activities for Persons with Dementia (Vol. 2)*. Beachwood, OH: Menorah Park Press.

Camp, C. J., Judge, K. S., Bye, C. A., Fox, K. M., Bowden, J., Bell, M., et al. (1997). An intergenerational program for persons with dementia using Montessori methods. *The Gerontologist, 37*, 688-692.

Camp, C. J., & Mattern, J. M. (1999). Innovations in managing Alzheimer's disease. In D. E. Biegel & A. Blum (Eds.), *Innovations in Practice and Service Delivery Across the Lifespan* (pp. 276-294). New York: Oxford University Press.

Camp, C. J., Vance, D., Kabacoff, M., & Greenwalt, L. (1996). Montessori methods: Innovative interventions for adults with Alzheimer's disease. *Montessori Life, 10*, 12-13.

Canadian Institute for Health Information (CIHI). (2010, August). *Caring for Seniors with Alzheimer's Disease and Other Forms of Dementia*. Accessed April 18, 2011, from http://secure.cihi.ca/cihiweb/products/Dementia_AIB_2010_EN.pdf

Card, J. A. (1989). Perceived leisure functioning of nursing home patients: Does recreation make a difference? *Activities, Adaptation and Aging, 13*(1/2), 29-40.

Cerveo, R. M. (1985). Continuing professional education and behaviour change: A model for research and evaluation. *Journal of Continuing Education in Nursing, 16*, 85-88.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage.

Charmaz, K. (2008). Grounded theory as an emergent method. In S.N. Hesse-Biber & P. Leavy (Eds.), *Handbook of Emergent Methods* (pp. 155-170). New York: Guilford Press.

Clarke, A. E., & Shim, J. (2011). Medicalization and biomedicalization revisited: Technoscience and transformations of health, illness and American medicine. In B.A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), *Handbook of the Sociology of Health, Illness, and Healing* (pp. 173-199). New York, NY: Springer.

Cohen-Mansfield, J. (2000). Approaches to the management of disruptive behaviours. In M. P Lawton, & R. L. Rubinstein (Eds.), *Interventions in Dementia Care: Towards Improving Quality of Life*. New York, NY: Springer Publishing.

Cohen-Mansfield, J., & Bester, A. (2006). Flexibility as a management principle in dementia care: The Adards example. *The Gerontologist, 46*(4), 540-544.

Community Care Access Centre (CCAC). (2012a). *Long-Term Care Options: Understanding Your Options*. Accessed May 10, 2012, from, http://www.ccac-ont.ca/Content.aspx?EnterpriseID=15&LanguageID=1&MenuID=22

Community Care Access Centre (CCAC). (2012b). *Long-Term Care Options: Eligibility and Admission*. Accessed May 10, 2012, from, http://www.ccac-ont.ca/ Content.aspx?EnterpriseID=15&LanguageID=1&MenuID=23

Coppola, D., Feldheim, I., Kennaley, J., & Steinberg, A. (1990). Developing a sense of community: A programming approach for institutionalised elderly. *Activities, Adaptation and Aging, 14*(3), 17-25.

Corazzini, K. N., McConnell, E. S., Anderson, R. A., Reed, D., Champagne, M. T., Lekan, D., et al. (2010). The importance of organizational climate to training needs and outcomes in long-term care. *Alzheimer's Care Today, 11*(2), 109-121.

Crispi, E. L., & Heitner, G. (2002). An activity-based intervention for caregivers and residents with dementia in nursing homes. *Activities, Adaptation and Aging, 26*(4), 61-72.

Davis, J. E. (2010). Medicalization, social control, and the relief of suffering. In W. C. Cockerham, (Ed.), *The New Blackwell Companion to Medical Sociology* (pp. 211-241). Malden, MA: Blackwell Publishers.

De Leeuw, E. D. (2005). To mix or not to mix data collection modes in surveys. *Journal of Official Statistics, 21*(2), 233-255.

DementiAbility. (2012). *Montessori Methods for Dementia™.* Accessed June 27, 2012, from http://www.dementiability.com/

Dempsey, N. P., & Pruchno, R. A. (1993). The family's role in the nursing home: Predictors of technical and non-technical assistance. *Journal of Gerontological Social Work, 21*(1/2), 127-145.

Dillman, D. A. (2007). *Mail and Internet Surveys: The Tailored Design Method* (2nd ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Dommeyer, C.J., & Moriarty, E. (1999). Comparing two forms of an e-mail survey: Embedded vs. attached. *International Journal of Market Research, 42*(1), 39-50.

Ducak, K., & Keller, H. (2011). Menu planning in long-term care: Toward resident-centred menus. *Canadian Journal of Dietetic Practice and Research, 72*(2), e126-133.

Duncan, M. T., & Morgan, D. L. (1994). Sharing and caring: Family caregivers' views of their relationships with nursing home staff. *The Gerontologist, 34*(2), 235-244.

Duncan-Myers, A. M., & Huebner, R. A. (2000). Relationship between choice and quality of life among residents in long-term care facilities. *The American Journal of Occupational Therapy, 54*(5), 504-508.

Dupuis, S. L., Gillies, J., Carson, J., Whyte, C., Genoe, R., Loiselle, L., et al. (2012). Moving beyond patient and client approaches: Mobilizing 'authentic partnerships' in dementia care, support and services. *Dementia, 11*(4) 427-452.

Dupuis, S. L., & Luh, J. (2005). Understanding responsive behaviours: The importance of correctly perceiving triggers that precipitate residents' responsive behaviours. *Canadian Nursing Home, 16*(1), 29-34.

Dupuis, S. L., & Norris, J. E. (1997). A multidimensional and contextual framework for understanding diverse family members' roles in long-term care facilities. *Journal of Aging Studies, 11*(4), 297-325.

Dupuis, S. L., & Norris, J. E. (2001). The roles of adult daughters in long-term care facilities: Alternative role manifestations. *Journal of Aging Studies, 15*(1), 27-54.

Dupuis, S.L., & Pedlar, A. (1995). Family leisure programs in institutional care settings. Buffering the stress of caregivers. *Therapeutic Recreation Journal, 29*(3), 184-205.

Dupuis, S. L., Smale, B., & Wiersma, E. (2003, August). *In-House and Community Access Recreation Programmes in Long-Term Care Facilities in Canada: Final Report.* Murray Alzheimer Research and Education Program (MAREP), University of Waterloo. Waterloo, ON: MAREP.

Dupuis, S. L., & Wiersma, E. (2006, November). *Meanings attached to responsive behaviours in long-term care settings.* Paper presented at the 28th National Conference of the Alzheimer Society of Canada, Toronto, Ontario, Canada.

Dupuis, S. L., & Wiersma, E. (2007, November*). Pathologizing behaviour: The role of long-term care.* Paper presented at the 36th Annual Scientific and Educational Meeting of the Canadian Association on Gerontology, Calgary, Alberta, Canada.

Dupuis, S. L., Wiersma, E., & Loiselle, L. (2012). Pathologizing behaviour: Meanings of behaviour in dementia care. *Journal of Aging Studies, 26*, 162-173.

Elliot, G. (2010). *Montessori Methods for Dementia: A Focus on the Person and the Prepared Environment.* Hamilton, ON: McMaster University, Gilbrea Centre for Studies in Aging.

Elliot, G. (2011). *Montessori Methods for Dementia™: Focusing on the Person and the Prepared Environment.* Hamilton, ON: McMaster University, Gilbrea Centre for Studies in Aging.

Edvardsson, D., Winblad, B., & Sandman, P. O. (2008). Person-centred care of people with severe Alzheimer's disease: Current status and ways forward. *The Lancet Neurology, 7*, 362-367.

Estes, C. L. (2001). The political economy of aging: A theoretical framework. In C. L. Estes and Associates (Eds.), *Social Policy and Aging: A Critical Perspective*. (pp. 1-22). Thousand Oaks, CA: Sage Publications Inc.

Estes, C. L., Harrington, C., & Pellow, D. N. (2001). The medical-industrial complex and the aging enterprise. In C. L. Estes and Associates (Eds.), *Social Policy and Aging: A Critical Perspective*. (pp. 165-185). Thousand Oaks, CA: Sage Publications Inc.

Estes, C. L., Linkins, K. W., & Binney, E. A. (2001). Critical perspectives on aging. In C.L. Estes and Associates (Eds.), *Social Policy and Aging: A Critical Perspective*. (pp. 23-44). Thousand Oaks, CA: Sage Publications Inc.

Estes, C. L., Mahakian, J. L., & Weitz, T. A. (2001). A political economy critique of "productive aging". In C. L. Estes and Associates (Eds.), *Social Policy and Aging: A Critical Perspective*. (pp. 187-199). Thousand Oaks, CA: Sage Publications Inc.

Fitzsimmons, S. (2001). Easy rider wheelchair biking. A nursing-recreation therapy clinical trial for the treatment of depression. *Journal of Gerontological Nursing, 27*(5), 14-23.

Fletcher, S., Zimmerman, S., Preisser, J. S., Mitchell, C. M., Reed, D., Gould, E., et al. (2010). Implementation fidelity of a standardized dementia care training program across multiple trainers and settings. *Alzheimer's Care Today, 11*(1), 51-60.

Folstein, M., Folstein, S., & McHugh, P. (1975). "Mini-Mental State" a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12, 189–198.

Garbett, R., & McCormack, B. (2002). A concept analysis of practice development. *Nursing Times Research, 7*(2), 87-100.

Garrison, R. (2011a). *The Art and Science of Research Interviewing*. York, ON: Institute for Social Research, York University.

Garrison, R. (2011b). *Interpreting Qualitative Data: An Overview*. York, ON: Institute for Social Research, York University.

Gerdner, L. A. (2000). Effects of individualized versus classical "relaxation" music on the frequency of agitation in elderly persons with Alzheimer's disease and related disorders. *International Psychogeriatrics, 12*, 49-65.

Giroux, D., Robichaud, L., & Paradis, M. (2010). Using the Montessori approach for a clientele with cognitive impairments: A quasi-experimental study design. *International Journal of Aging and Human Development, 71*(1), 23-41.

Gould, E., & Reed, P. (2009). Alzheimer's Association quality care campaign and professional training initiatives: Improving hands-on care for people with dementia in the U.S.A. *International Psychogeriatrics, 21*, S25-S33.

Green, L. & Kreuter, M. W. (1991). *Health promotion planning. An educational and environmental approach*, (2nd ed.). Toronto, ON: Mayfield Publishing Co.

Hasselkus, B. (1992). Physician and family caregiver in the medical setting: Negotiation of care? *Journal of Aging Studies, 6*(1), 67-80.

Health Professions Regulatory Advisory Council (HPRAC). (2006, April). *Regulation of Health Professions in Ontario: New Directions*. Accessed February 20, 2011, from, http://www.hprac.org/en/reports/resources/PSW-FinalReportSept27-06.pdf

Hellen, C. R. (1998). *Alzheimer's Disease: Activity-Focused Care*. Boston: Butterworth-Heinmann.

Hirdes, J. P. (2002). Long-term care funding in Canada. *Journal of Aging & Social Policy, 13*(2), 69-81.

Hyer, K., Molinari, V., Kaplan., M., & Jones, S. (2010). Credentialing dementia training: The Florida experience. *International Psychogeriatrics, 22*(S.I. 6), 864-873.

Jarrott, S. E., Gozali, T., & Gigliotti, C. M. (2008). Montessori programming for persons with dementia in the group setting: An analysis of engagement and affect. *Dementia, 7*(1), 109-125.

Judge, K. S., Camp, C. J., & Orsulic-Jeras, S. (2000). Use of Montessori-based activities for clients with dementia in adult day care: Effects on engagement. *American Journal of Alzheimer's Disease, 15*(1), 42-46.

Katsinas, R. P. (2000). The use and implications of a canine companion in a therapeutic day program for nursing home residents with dementia. *Activities, Adaptation and Aging, 25*(1), 13-30.

Kitwood, T. (1997). *Dementia Reconsidered: The Person Comes First*. Buckingham, England: Open University Press.

Kolanowski, A. M., Litaker, M., & Buettner, L. (2005). Efficacy of theory-based activities for behavioural symptoms of dementia. *Nursing Research, 54*(4), 219-228.

Kontos, P. C., Miller, K-L., Mitchell, G. J., & Cott, C. A. (2010). Dementia care at the intersection of regulation and reflexivity: A critical realist perspective. *Journal of Gerontology: Social Sciences*, *66B*(1), 1-10.

Kruzick, J. M. (2004). Ownership, chain affiliation, and administrator decision-making autonomy in long-term care facilities. *Administration in Social Work, 29*(1), 5-24.

Kuske, B. B., Hanns, S., Luck, T., Angermeyer, M. C., Behrens, J., & Riedel-Heller, S. G. (2007). Nursing home staff training in dementia care: A systematic review of evaluated programs. *International Psychogeriatrics, 19*(5), 818-841.

Lanoix, M. (2005). No room for abuse. *Cultural Studies, 19*(6), 719-736.

Lilley, J., & Jackson, L. (1990). The value of activities: Establishing a foundation for cost-effectiveness – A review of the literature. *Activities, Adaptation and Aging, 14*(4), 5-20.

Local Health Integration Network (LHIN). (2012). *Ontario's Local Health Integration Networks Map*. Retrieved April 20, 2012, from, http://www.lhins.on.ca/ FindYourLHIN.aspx

Logsdon, R. G. (2000). *Behavioral outcomes of dementia special care units: Results from four of the NIA collaborative studies*. Paper presented at the symposium, Behavioral Findings, Measures, and Clinical Approaches to Dementia Care at the 53rd Annual Scientific Meeting of the Gerontological Society of America; Washington, DC.

Lopez, S. H. (2006). Culture change management in long-term care: A shop-floor view. *Politics & Society, 34*(1), 55-80.

Lopez, S. H. (2007). Efficiency and the fix revisited: Informal relations and mock routinization in a nonprofit nursing home. *Qualitative Sociology, 30*, 225-247.

Malone, M. L., & Camp, C. J. (2007). Montessori-Based Dementia Programming®: Providing tools for engagement. *Dementia, 6*(1), 150-157.

Martin, S., & Smith, R. W. (1993). OBRA legislation and recreational activities: Enhancing personal control in nursing homes. *Activities, Adaptation and Aging, 17*(3), 1-13.

McCabe, M. P., Davison, T. E., & George, K. (2007). Effectiveness of staff training programs for behavioural problems among older people with dementia. *Aging & Mental Health, 11*(5), 505-519.

McCainey, C. A., Stolee, P., Hillier, L. M., Harris, D., Hamilton, P., Kessler, L., et al. (2007). Evaluation of the sustained implementation of a mental health learning initiative in long-term care. *International Psychogeriatrics, 19*, 842-858.

McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., et al. (2010). Developing person-centred practice: Nursing outcomes arising from changes to the care environment in residential settings for older people. *International Journal of Older People Nursing, 5*, 93-107.

McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing, 56*(5), 472-479.

McCormack, B., Manley, K., & Walsh, K. (2008). Person-centred systems and processes. In Manley, K., McCormack, B., & Wilson, V. (Eds.), *International Practice Development in Nursing and Healthcare*. Oxford: Blackwell Publishing, pp. 17-41.

McGrail, K. M., McGregor, M. J., Cohen, M., Tate, R. B., & Ronald, L. A. (2007). For-profit versus not-for-profit delivery of long-term care. *Canadian Medical Association Journal, 176*(1), 57-58.

McGregor, M. J., Cohen, M., McGrail, K., Broemeling, A. M., Adler, R. N., Schulzer, M., et al. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? *Canadian Medical Association Journal, 172*(5), 645-649.

McMaster University. (2012). *Bridging Neurosciences with Social Sciences*. Accessed August 1, 2012, from, http://www.socialsciences.mcmaster.ca/news-and-events/bridging-neurosciences-with-social-sciences

Ministry of Health and Long-Term Care (MOHLTC). (2011a). *Reports on Long-Term Care Homes - Search for LTC Homes by Home Name*. Accessed August 1, 2012, from, http://publicreporting.ltchomes.net/en-ca/default.aspx

Ministry of Health and Long-Term Care (MOHLTC). (2011b). *Long-Term Care Homes Act, 2007, Ontario Regulation 79/10*. Accessed May 10, 2012, from, http://www.e-laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10079_e.htm

Ministry of Health and Long-Term Care (MOHLTC). (2011c). *Long-Term Care Homes Act, 2007*. Accessed May 10, 2012, from, http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_07l08_e.htm

Ministry of Health and Long-Term Care (MOHLTC). (2012a). *Seniors' Care: Long-Term Care Homes*. Accessed August 1, 2012 from, http://www.health.gov.on.ca/en/public/programs/ltc/15_facilities.aspx

Ministry of Health and Long-Term Care (MOHLTC). (2012b). Rate reduction in Long-Term Care Homes. Accessed May 10, 2012, from, http://www.health.gov.on.ca/en/public/programs/ltc/15_facilities_rate_reduction.aspx

Mitchell, C. M., Zimmerman, S., & Beeber, A. S. (2010). Dementia care training for long-term care staff. If you provide it, will they come? *Alzheimer's Care Today, 11*(1), 40-50.

Morgan, D. G., Stewart, N. J., D'Arcy, C., Forbes, D., & Lawson, J. (2005). Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units. *Journal of psychiatric and mental health nursing, 12,* 347-358.

Moyle, W., Hsu, M. C., Lieff, S., & Vernooij-Dassen, M. (2010). Recommendations for staff education and training for older people with mental illness in long-term aged care. *International Psychogeriatrics, 22*(7), 1097-1106.

Murphy, K. (2007). Nurses' perception of quality and the factors that affect quality care for older people living in long-term care settings in Ireland. *Journal of Clinical Nursing, 16*, 873-884.

Murphy, K., Shea, E. O., & Cooney, A. (2007). Quality of life for older people living in long-stay settings in Ireland. *Journal of Clinical Nursing, 16*, 2167-2177.

Murray Alzheimer Research and Education Program (MAREP). (2012). *Understanding Responsive Behaviours*. Accessed June 21, 2012, from, http://www.marep.uwaterloo.ca/PDF/MAREP%20term%20of%20RB%20and%20philosophy%202012.pdf

National Union of Public and General Employees (NUPGE). (2007, February). *Dignity Denied: Long-term care and Canada's Elderly*. Accessed February 22, 2011, from, http://www.nupge.ca/files/publications/Medicare/Dignity_Denied.pdf

Neutens, J. J., & Rubinson, L. (2002). *Research Techniques for the Health Sciences*, (3rd ed.). San Francisco, CA: Benjamin Cummings.

Nolan, M. R., Davies, S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond 'person-centered' care: A new vision of gerontological nursing. *International Journal of Older People Nursing, 13*(3a), 45–53.

Nolan, M., Davies, S., Brown, J., Wilkinson, A., Warnes, T., McKee, K., et al. (2008). The role of education and training in achieving change in care homes: A literature review. *Journal of Research in Nursing, 13*(5), 411-433.

Nolan, M., Ryan, T., Enderby, P., & Reid, D. (2002). Towards a more inclusive vision of dementia care practice and research. *Dementia, 1*, 193–211.

Ontario Health Coalition. (2008, May). *Violence, Insufficient Care, and Downloading of Heavy Care Patients: An evaluation of increasing need and inadequate standards in Ontario's nursing homes.* Accessed February 19, 2011, from, http://www.web.net/ohc/may08ltcreport.pdf

Orsulic-Jeras, S., Judge, K.S., Camp, C.J. (2000). Montessori-based activities for long-term care residents with advanced dementia: Effects on engagement and affect. *The Gerontologist, 40*(1), 107-111.

Orsulic-Jeras, S., Schneider, N. M., Camp, C. J., Nicholson, P., & Helbig, M. (2001). Montessori-based dementia activities in long-term care: Training and implementation. *Activities, Adaptation and Aging, 25*(3-4), 107-120.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods* (2nd ed.). Newbury Park, CA: Sage Publications.

Phinney, A., Chaudhury, H., & O'Connor, D. (2007). Doing as much as I can do: The meaning of activity for people with dementia. *Aging and Mental Health, 11*, 384-393.

Pratt, C. C., Schmall, V., Wright, S., & Hare, J. (1987). The Forgotten Client: Family Caregivers of Institutionalized Dementia Patients. In Brubaker, T. H. (Ed.), *Aging, Health, and Family* (pp. 197-213). Newbury Park: Sage Publications.

Quadagno, J., & Reid, J. (1999). The Political Economy Perspective in Aging. In Bengtson, V.L., & Schaie, K.W. (Eds.), *Handbook of Theories of Aging* (pp. 344-358). New York: Springer Publishing Company.

Rachlis, M. (2000, September). *The Hidden Costs of Privatization: An International Comparison of Community Care*. Written for the Canadian Centre for Policy Alternatives. Accessed February 19, 2011 from, http://www.michaelrachlis.com/publications.php

Rampatige, R., Dunt, D., Doyle, C., Day, S., and van Dort, P. (2009). The effect of continuing professional education on health care outcomes: Lessons for dementia care. *International Psychogeriatrics, 21*, S34-S43.

Robichaud, L., Durand, P. J., Bedard, R., & Ouellet, J-P. (2006). Quality of life indicators in long term care: Opinions of elderly residents and their families. *The Canadian Journal of Occupational Therapy, 73*(4), 245-251.

Rosling, L. K. & Kitchen, J. (1992). Music and drawing with institutionalized elderly. *Activities, Adaptation & Aging, 17*(2), 27-38.

Rubin, A., & Shuttlesworth, G. E. (1983). Engaging families as support resources in nursing home care: Ambiguity in the subdivision of tasks. *The Gerontologist, 23*(6), 632-636.

Russen-Rondinone, T., & DesRoberts, A. M. (1996). STIR—Success Through Individual Recreation: Working with the low-functioning resident with dementia or Alzheimer's disease. *American Journal of Alzheimer's Disease and Other Dementias, 11*, 32-35.

Schneider, N. M., & Camp, C. J. (2002). Use of Montessori-based activities by visitors of nursing home residents with dementia. *Clinical Gerontologist, 26*(1-2), 71-84.

Schreiner, A. S., Yamamoto, E., & Shiotani, H. (2005). Positive affect among nursing home residents with Alzheimer's dementia: The effect of recreational activity. *Aging and Mental Health, 9,* 129–134.

Schwartz, A. N., & Vogel, M. E. (1990). Nursing home staff and resident's families role expectations. *The Gerontologist, 30*(1), 49-53.

Sharkey, S. (2008, May). *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-term care Homes.* A Report of the Independent Review of Staffing and Care Standards for Long-term care Homes in Ontario. Ministry of Health and Long-term care, Toronto, ON. Accessed February 22, 2011, from, http://www.health.gov.on.ca/english/public/pub/ministry_reports/staff_care_ standards/staff_care_standards.pdf

Shary, J. M., & Iso-Ahola, S. E. (1989). Effects of a control-relevant intervention on nursing home residents' perceived competence and self-esteem. *Therapeutic Recreation Journal, 23*(1), 7-15.

Sheehan, K. (2001). E-mail survey response rates: A review. *Journal of Computer-Mediated Communication, 6*(2).

Shuttlesworth, G. E., Rubin, A., & Duffy, M. (1982). Families versus institutions: Incongruent role expectations in the nursing home. *The Gerontologist, 22*(2), 200-208.

Silverman, D. (2010). *Doing Qualitative Research*. (3rd ed.). Thousand Oaks, CA: Sage Publications Ltd.

Skrajner, M. J., Malone, M. L., Camp, C. J., McGowan, A., & Gorzelle, G. J. (2007). Montessori-Based Dementia Programming®. *Alzheimer's Care Quarterly, 8*(1), 53-64.

Smith, M. (2004, May). *Commitment to Care: A Plan for Long-Term Care in Ontario*. Ministry of Health and Long-Term Care, Toronto, ON. Accessed June 20, 2012, from, http://www.oanhss.org/AM/Template.cfm?Section=External_Reports& Template=/CM/ContentDisplay.cfm&ContentID=4545

Stolee, P., Esbaugh, J., Aylward, S., Cathers, T., Harvey, D. P., Hillier, L. M., et al. (2005). Factors associated with the effectiveness of continuing education in long-term care. *The Gerontologist, 45*(3), 399-405.

Stolee, P., McCainey, C., Hillier, L. M., Harris, D., Hamilton, P., Kessler, L., et al. (2009). Sustained transfer of knowledge to practice in long-term care: Facilitators and barriers of a mental health learning initiative. *Gerontology & Geriatrics Education, 30*(1), 1-20.

Sullivan, A., Pedlar, A., & Miller, B. (2002). Experiencing leisure on a cognitive support unit. *Society and Leisure, 25*(2), 443-469.

Trzinski, A., & Higgins, J. (2001). Therapeutic play: Building cohesion and socialization among nursing home residents. *Activities, Adaptation & Aging, 25*(3/4), 121-136.

Van Haitsma, K. (2000). The assessment and integration of preferences into care practices for persons with dementia residing in the nursing home. In R. L. Rubinstein, M. Moss, & M. H. Kleban (Eds.), *The Many Dimensions of Aging* (pp. 143-163). New York: Springer.

Van Haitsma, K., & Ruckdeschel, K. (2001). Special care for dementia in nursing homes: Overview of innovations in programs and activities. *Alzheimer's Care Quarterly, 2*(3), 49-56.

Vance, D., Camp, C., Kabacoff, M., & Greenwalt, L. (1996). Montessori method: Innovative interventions for adults with Alzheimer's disease. *Montessori Life*, *8*, 10-11.

Voelkl, J. E., Fries, B. E., & Galecki, A. T. (1995). Predictors of nursing home residents' participation in activity programs. *The Gerontologist, 35*(1), 44-51.

Volicer, L., Simard, J., Heartquist Pupa, J., Medrek, R., & Riordan, M. E. (2006). Effects of continuous activity programming on behavioural symptoms of dementia. *Journal of the American Medical Directors Association, 7*, 426-431.

Ward, C. R., Kamp, L. L., & Newman, S. (1996). The effects of participation in an intergenerational program on the behaviour of residents with dementia. *Activities, Adaptation and Aging, 20*(4), 61-76.

Wiersma, E., & Dupuis, S. L. (2010). Becoming institutional bodies: Socialization into a long-term care home. *Journal of Aging Studies, 24*, 278-291.

Zarit, S. H., & Whitlatch, C. J. (1992). Institutional placement: Phases of transition. *The Gerontologist, 32*(5), 665-672.

Zimmerman, S., Sloane, P. D., Williams, C. S., Reed, P. S., Preisser, J. S., Eckert, J. K., et al. (2005a). Dementia care and quality of life in assisted living and nursing homes. *The Gerontologist, 45*(S.I. 1), 133-146.

Zimmerman, S., Williams, C. S., Reed, P. S., Boustani, M., Preisser, J. S., Heck, E., et al. (2005b). Attitudes, stress, and satisfaction of staff who care for residents with dementia. *The Gerontologist, 45*(S.I. 1), 96-105.

9.0 Appendices

Appendix A - Telephone Interview Questions

Individual/demographic questions

1. In what year were you born?

2. What is the highest level of education you have achieved?
   a. Do you have any professional or formal designations? (Such as Activity professional, RN, OT, PSW, etc.)
   b. Other than Montessori Methods for Dementia, have you taken any other dementia care courses or workshops? If so, which ones?

3. What is your position/role where you work?
   a. How long have you worked there?
   b. Approximately what percentage of your time is spent working directly with persons with dementia?
   c. Approximately how many people are in your care where you work?
   d. How many years have you worked in dementia care?

Experience in the program

4. What drew you to the Montessori Methods for Dementia workshop?
   (What was it about this particular workshop that appealed to you? Why did you attend the workshop?)
   a. How did you hear about it?
   b. Who paid for your Montessori Methods for Dementia training? (Was it you or your employer?)

5. How useful or effective did you find the Montessori Methods for Dementia training?
   (What did you learn from the training? How was your experience of the training?)
   a. In which ways did you find it useful or effective?
   b. If not, why not?
      (For both a & b, was it something to do with how it was taught, the content, the workbook or materials provided, your memory of it, and/or something else?)
   c. What could have been done differently? (Do you have any suggestions for how it could be improved?)

6. What Montessori Methods for Dementia resources have you purchased or needed?
   a. Did you purchase the Montessori Methods for Dementia Montessori kit?
      i. If so, has it been useful for you?
      ii. If you didn't purchase the kit, why not?

Appendix A - Telephone Interview Questions (continued)

    b. Have you purchased any other Montessori Methods for Dementia materials, such as the Montessori Methods for Dementia: Focusing on the Person and the Prepared Environment book that was published this year, reading books, memory book, or The Memories Ain't Gone DVD?
        i. If so, which have been useful for you?
        ii. If you haven't purchased any other materials, why not?

    c. Have you needed any follow-up assistance or support from the Montessori Methods for Dementia/Gilbrea Centre for Studies in Aging staff?
        i. If so, what for?
        ii. If not, why not?
        iii. Are there any forms of follow-up assistance or continuing education regarding Montessori Methods for Dementia that would be useful for you? (Such as a refresher session in-person or online, networking opportunities, online resource area, etc.?)

Experience implementing the program

7. What is the history of Montessori Methods for dementia where you work? (Was Montessori Methods for Dementia already being used where you work or were you the first person to try and put it into practice there?)
    a. If it was already being used where you work, how did you help put it into practice? (What was your role in implementing it?)
    b. If you were the first person to try and put it into practice, how did you go about doing that?
    c. Were you able to successfully put Montessori Methods for Dementia into practice where you work?
        i. Do you use it will all persons in your care or just some? (If just some, why is that?)

8. What were some of the factors or things that helped make Montessori Methods for Dementia easier to implement?

9. What were some of the barriers or challenges you encountered when putting/attempting to put Montessori Methods for Dementia into practice at your workplace?
    a. How did you address these barriers or challenges? (Were you able to overcome any of these barriers or challenges? If so, how?)
    b. Do you still face some of these barriers? If so, which ones?
        i. How would you suggest overcoming these barriers? (What would you like to do to overcome these barriers?)

Appendix A - Telephone Interview Questions (continued)

Ask if not already addressed:

10. What support did you receive from your supervisor/manager when implementing Montessori Methods for Dementia where you work?
    > (What types of support, and in which ways? If you didn't receive any support from your supervisor/manager, why do you think that is?)

11. What support did you receive from fellow staff members when implementing Montessori Methods for Dementia where you work?
    > (What types of support, and in which ways? If you didn't receive any support from your colleagues, why do you think that is?)

12. What structural or organizational challenges did you face when implementing Montessori Methods for Dementia where you work?
    (For instance, did you have enough funding, space and/or other resources, such as materials or equipment? If so, in which ways? If not, why not?)
    a. How did you address these barriers or challenges? (Were you able to overcome any of these barriers or challenges? If so, how?)
    b. Do you still face some of these barriers? If so, which ones?
        i. How would you suggest overcoming these barriers? (What would you like to do to overcome these barriers?)

Changes you have noticed since implementing the program

13. What are some of the changes or results you have noticed since using Montessori Methods for Dementia where you work? (With yourself, residents and their families, and other staff – both positive and negative?)
    a. How has it enhanced the quality of life of residents? (Have you found opportunities to give residents new roles and routines?)
    b. How has it enhanced the work life of staff, including yourself?
    c. How has it enhanced the care experiences of family members and friends?

Last question

14. Is there anything we haven't talked about regarding putting/attempting to put Montessori Methods for Dementia into practice where you work that you feel is important and would like to discuss?